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Dynamics of Change in Communities: The governance of organizational and cultural evolution

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Abstract

The Emmanuel Community, a long-standing Italian organization in the field of addiction, has undergone a significant transformation, mirroring changes in community-based organizations. It has shifted from hospitality-based care for marginalized users to structured treatment centers, moving from a total system logic to healthcare-oriented interventions. This study aims to map the organizational culture within the community, analyzing how cultural change interacts with organizational inertia and identifying models that guide professionals in integrating the autonomy of the network. Through the online administration of a battery of questionnaires, the responses of 95 participants were collected. The data was analyzed using Multiple Correspondence Analysis and Cluster Analysis. The results showed that the Emmanuel community is characterized by five symbolic universes: *Idealizers, Self-referential, Professional Communities, Disengaged, Disillusioned*. These clusters show how change has introduced standardized practices and responsibilities, improving the measurement of treatment but potentially

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weakening the relational and inclusive aspects, reducing empathy and patient participation. The results suggest the need to balance professionalization with the traditional values of the community to maintain an effective and human-centered treatment model.

Keywords: therapeutic community, organizational culture, dynamics of change, sense making, symbolic universe.

Introduction

As it is currently represented and organized, despite its variations, the therapeutic community for people with substance use disorders is the product of a complex process of experimentation and integration that is still ongoing.

The first developments in the Italian context, closely linked to the actions of religious groups and volunteer organizations, date back to the 1970s. These communities were initially not oriented by a well-defined model, distinguishing themselves more as life communities rather than therapeutic ones, guided by altruistic values and a strong social and political commitment. From this perspective, the founding of the Gruppo Abele by Don Luigi Ciotti, which in 1974 established the first Italian agricultural community for drug addicts in Murisengo, marks a key event. In 1982, Gruppo Abele also promoted the creation of the National Coordination of Reception Communities (CNCA), which today encompasses approximately 250 groups and associations. Among the most significant realities are also CeIS of Don Picchi, the Italian Federation of Therapeutic Communities (FICT), Emmaus, Samman, Incontro community, and Emmanuel community.

The communities have therefore witnessed a progressive expansion of their organizational structure, as well as of their diffusion and differentiation across the territory. This has served as evidence of the initial proposals of the value-based community model, leading in the 1990s to formal recognition by public services with the 1990 Agreement Act, followed by accreditation and funding of the structures by the relevant state agencies. This, in turn, led to the introduction of more stringent regulations and quality standards to be observed, requiring adjustments in terms of hygiene, service quality, and staff

qualifications. The communities thus became official partners of the Public Addiction Services (SerT), fully integrating into the Social-Health Services System.

This progressive expansion – in terms of the spread or structuring of the facilities, and the variability of the user base – has inevitably exposed the community model to the weakening of its original model. Several authors (Browne, 2001; De Leon, 2000; Sullivan & Moore, 2010; Ward & Allsop, 2004) have highlighted this significant process of change over the years, emphasizing the shift from an initial user base consisting of individuals with severe and chronic substance use disorders to an increasingly complex population with growing psychiatric comorbidities, mood disorders, anxiety syndromes, etc. Originally, the communities were characterized as places of hospitality, where value was attributed to internal relationships and the participation of residents in daily practices. Care was based on assimilation into the community system, following its regularities, and belonging to this reality. Today, the community has become a residential treatment center, required to meet all the demands of the National Health Service, creating an individualized therapeutic rehabilitation program (PTRI) for each user, and beginning to experiment with the idea that value is tied to the professional services provided, rather than to membership in the system.

This remains a significant challenge for the therapeutic community, representing an opportunity to develop its symbolic and relational heritage in order to integrate value-based models, rooted in meaning and foundational motivations, with professional models related to the integration of new professionals and organizational models. This is even more important if one considers that organizational culture plays a crucial role within organizations, influencing individual behavior, management concepts and the overall functioning of the organization (Chatman *et al.*, 2014; Morris *et al.*, 2015). Consequently, organizational culture can be understood as the degree to which the members of an organization construct, internalize and share fundamental values, which in turn influence the operational dynamics and organizational results (Cameron & Quinn, 2011).

In this context, the ongoing professionalization process and alignment with accreditation criteria, initiated in the 1990s, continues to drive therapeutic communities toward a transition from value-based

entities to organizations increasingly oriented toward professionalism. Our research group hypothesizes that this process, like all organizational processes, requires careful and structured governance to ensure inclusivity and generativity, avoiding the risk of exclusion or fragmentation. To explore this dynamic, we have conducted a case study within the Emmanuel community to understand the challenges and opportunities associated with adapting to the new required standards.

The research aims to analyze the organizational transformation process of the Emmanuel community, with the goal of integrating the cultural and value heritage accumulated over more than 40 years of activity. Specifically, it seeks to map the different organizational cultures within the community, identifying prevailing action models and possible directions for development.

Theoretical Framework

The present study adopted the Semiotic Cultural Psychology Theory (SCPT; Salvatore, 2016; Salvatore *et al.*, 2019; Valsiner, 2007), which integrate cultural psychology and psychoanalysis, providing a broader model of the relationship between mind, meaning, subject, behavior, and society (Salvatore *et al.*, 2022, 2024). The SCPT conceives of culture as a dynamic process and mental processes as a continuous activity of sensemaking that structures experience (Salvatore *et al.*, 2019). According to this perspective, individuals do not simply apply invariant cognitive rules in their interaction with reality, but orient their interpretation through generalized meanings, embedded in the cultural context (Reho, 2025). Meaning, therefore, is not an intrinsic attribute of objects, but rather the product of the sensemaking process, which shapes the way in which the world is perceived and represented by the mind (Reho & Salvatore, 2024). In other words, reality is not configured as a set of discrete entities to be represented and interpreted, but as a continuous flow of events, from which sensemaking selects and organizes specific elements, generating a relatively stable structure of experience (Salvatore *et al.*, 2024).

This process is based on generalized, affect-laden and culturally-grounded meanings that operate as latent hypotheses about the nature of the world and the criteria according to which it should be interpreted

and acted upon (Salvatore *et al.*, 2019). These meanings influence individuals' emotions, beliefs, attitudes, opinions and decisions, orienting their experience of the physical and social world.

The SCPT conceptualizes these meanings through the notion of "Symbolic Universes" (Cremaschi *et al.*, 2021; Salvatore *et al.*, 2018; 2019), understood as cultural and plural constructs, not reducible to mere individual representations, but rather internalized through participation in social and discursive practices (Salvatore *et al.*, 2019). According to this perspective, community culture emerges as a specific expression of symbolic universes, taking the form of a system of shared meanings that guide the practices and behaviors of the actors involved. Therefore, the specific way in which individuals interact with the community environment is influenced by the symbolic universes active within it (Salvatore & Zittoun, 2011; Salvatore *et al.*, 2024). It follows that community culture is configured as the product of sensemaking processes, which manifest themselves through individual and collective representations. The latter, in turn, shape the behavioral patterns and operational dynamics adopted within the community (Maitlis & Christianson, 2014).

According to this theoretical framework, community culture can be defined as a system of shared representations that not only guide individual and collective action, but also act as a vector of identity and cohesion within the community itself (Chatman & O'Reilly, 2016). Individual representations contribute to the definition of conceptions and attitudes towards the community, determining the ways in which the actors interpret and pursue the objectives, to the point of outlining specific community identities (Maitlis & Christianson, 2014).

Symbolic Universes, therefore, are not given structures nor constructions imposed through a top-down process, but rather emerge as the result of the meaning individuals attribute to the community context. These interpretive processes translate into specific modes of action, which, in turn, form the basis for the definition of shared norms and values. In other words, symbolic universes represent a system of implicit meanings that not only orient, but at the same time constrain the ways in which individuals interpret and act in the community context.

Method

Procedure and Participants

The directors of the various centers involved in the study collected the contact details of all members of their respective teams. The research team used these contact details to send a message containing a link to the Google Forms online platform, where participants completed a battery of questionnaires. Data collection took place between August and October 2023.

All participants read the objectives and procedures of the study and gave their voluntary consent to participate without any compensation. The study was approved by the Ethics Committee for Research in Psychology, Department of Human and Social Sciences, University of Salento (Protocol No. 0000472, 25/03/2022). The research adhered to the guidelines set out in the Declaration of Helsinki, adopted by the World Medical Association (WMA) during the 18th General Assembly of the WMA held in Helsinki, Finland, in June 1964. Furthermore, the study complied with the amendments to the Declaration made during the 64th General Assembly of the WMA held in Fortaleza, Brazil, in October 2013.

A total of 144 messages were sent, resulting in 95 responses, corresponding to a response rate of 65.97%. The sample consisted of 47 women and 47 men (1 participant preferred not to answer this question), with an average age of 50.58 years (SD = 12.76). Regarding education, 1.1% of participants had a primary school certificate, 9.5% had a lower secondary school diploma, 24.2% had a high school diploma, 38.9% had a bachelor's degree, and 25.3% had a master's degree or an equivalent qualification.

Participants had the following roles: 23.2% were social-health operators, 15.8% were volunteers, 1.1% were doctors, 16.8% were psychologists or psychotherapists, 12.6% were educators, pedagogists, or social animators, 6.3% were social workers or sociologists, 16.8% were in coordination or management, and 3.2% had support roles (e.g., receptionist, administrative staff, baker). Participants reported an average tenure at the community of 15.05 years (SD = 11.94) and an average weekly working commitment of 30.23 hours (SD = 16.08). Additionally, 71.6% of participants had not worked in other

communities previously. The work location for participants was: 49.5% in Puglia, 16.8% in Basilicata, 15.8% in Campania, 6.3% in Lombardy, 4.2% in Piedmont, and 1.1% in Calabria.

Measures

An ad hoc questionnaire was administered to collect socio-demographic characteristics of the participants (gender, age, education, role, years of service, working hours, and location).

To investigate the ways in which the community is represented, mapping the symbolic universes active within it, the Survey of Essential Elements Questionnaire (SEEQ; Melnick & De Leon, 1999) was used, adapting it to the specific research needs. The SEEQ is a validated tool for analyzing the distinctive characteristics of therapeutic communities, with particular attention to the fundamental elements that characterize their organization, therapeutic processes and community atmosphere. Using 5 and 7 point Likert scales, various thematic dimensions were evaluated such as drug addiction and treatment, community interventions, relationships between staff and users, community life, therapeutic actions, user commitment and organizational climate.

Data Analysis

A preliminary phase of data analysis focused on identifying how the community was represented by analyzing responses to the SEEQ questionnaire through Multiple Correspondence Analysis (MCA) and Cluster Analysis (CA). The main factors extracted from the MCA were used for aggregation in the CA, which in turn identified a particular way of combining the responses from a group of respondents (i.e., a specific representation of the community). These analyses were performed using SPAD software (version 5.5).

Next, to explore the association between different representations and the socio-demographic characteristics of the participants, Chi-square tests were conducted. In case of a significant Chi-square result, standardized adjusted residuals were used as post-hoc tests (Agresti &

Franklin, 2016). SPSS software (version 26) was used for these analyses.

Results

The MCA extracted six factors that contributed more than 10% to the cumulative inertia. These factors explained 76.88% of the total inertia (Benzecri, 1992) and were used as classification criteria in the CA, which identified five clusters. The clusters (Table 1) were interpreted by the research team through a consensus procedure (Harris *et al.*, 2012) as follows:

Idealizers (35.8%): Characterized by a strongly idealized vision of the community, perceived as redemptive. Their responses were highly positive, with complete agreement on the importance of communal values, personal support, and individual responsibility. They also believed that sharing daily moments, such as meals, was very important for treatment.

Self-referential (27.4%): They believe the community functions as an authority and a model of behavior. They highly value the importance of remission through the development of personal identity and a global change in lifestyle. They emphasize the role of charismatic leadership and the importance of community norms.

Professional Communities (18.9%): They recognize the value of human bonds in care. They positively evaluate interventions that promote participation, mutual aid, and the definition of personalized treatment plans. They believe in the integration of therapeutic goals and educational objectives.

Disengaged (7.4%): They show a low level of engagement and a neutral attitude towards the importance of interventions. They tend not to have strong opinions, and their level of participation is less significant.

Disillusioned (10.5%): They show skepticism towards the effectiveness of the treatment. They perceive the role of staff and the community values negatively. They have low expectations about the community's ability to produce significant changes.

Table 1. *Response Profiles Characterizing the Five Clusters Mapped*

Cluster 1. Idealizers			
Item	*Mode*	*V-test*	*p-value*
The staff acts as: a source of support and motivation	Extremely	6.06	< 0.001
The interventions at the therapeutic community emphasize: the community's values	Extremely	5.99	< 0.001
The interventions at the therapeutic community emphasize: the sense of belonging to the community	Extremely	5.98	< 0.001
The residents' job functions are related to clinical progress	Extremely	5.92	< 0.001
The interventions at the therapeutic community emphasize: the development of individual responsibility	Extremely	5.91	< 0.001
The community action promotes users' conflict resolution skills	Extremely	5.91	< 0.001
The community action emphasizes the development of personal decision-making skills	Extremely	5.89	< 0.001
The effectiveness of the therapeutic community: collaboration within the users' life context	Extremely relevant	5.81	< 0.001
Remission requires respect for personal values	Fully agree	5.67	< 0.001
Well-being reflects the quality of values	Fully agree	5.65	< 0.001
Cluster 2. Self-referential			
Item	*Mode*	*V-test*	*p-value*
The staff acts as: a behavioral model	Very	2.39	0.008
Remission from addiction involves the development of a personal identity and a global lifestyle change	Fully agree	2.38	0.009
The staff acts as: a reference of authority	Very	2.21	0.014
Community action: sharing mealtimes between staff and users	Missing response	2.08	0.019
Community action: peer discussions to change behaviors	Missing response	2.08	0.019
Therapeutic community effectiveness: availability of services and resources to support staff professionalism	Missing response	2.08	0.019
Community action: explicit and public discussions on behaviors	Missing response	2.08	0.019
Community action: peer discussions when community values are violated	Missing response	2.08	0.019
Community action: work is used as part of the therapeutic program	Missing Response	2.08	0.019

Therapeutic community effectiveness: the all-encompassing nature of the community experience for users	Missing response	2.08	0.019
Cluster 3. Professional Communitaries			
Item	*Mode*	*V-test*	*p-value*
Community action: promoting mutual aid and sharing among users	Quite positively	5.57	< 0.001
Job functions: promoting community values	Very relevant	5.13	< 0.001
Interventions at the therapeutic community emphasize: defining personalized treatment plans	Very	4.67	< 0.001
Community action: work is used as part of an educational process	Very	4.67	< 0.001
Remission requires respect for significant personal and collective values	Fully agree	4.41	< 0.001
Community action: users are taught to control their emotions	Very	4.33	< 0.001
Community action: daily activities have both therapeutic and educational goals	Quite positively	4.11	< 0.001
Job functions: developing a collaborative attitude toward the community	Very relevant	4.10	< 0.001
Interventions at the therapeutic community emphasize: participation in community life	Very	3.99	< 0.001
Community action: the community has a written set of rules to regulate user behavior	Quite positively	3.99	< 0.001
Cluster 4. Disengaged			
Item	*Mode*	*V-test*	*p-value*
Interventions at the therapeutic community emphasize: the multidimensionality of interventions (medical therapy, psychoeducational interventions, etc.)	Neutral	4.60	< 0.001
Interventions at the therapeutic community emphasize: the professionalism of the staff	Neutral	3.77	< 0.001
Job functions: moral growth of the user	Quite relevant	3.62	< 0.001
Remission from addiction involves the development of personal identity and a global lifestyle change (behaviors, attitudes, and values)	Quite agree	3.60	< 0.001
Community action: progress in treatment is reinforced by gaining more autonomy in community life	Neither positively nor negatively	3.39	< 0.001
The staff acts as: a facilitator of internal relationships in the community	Neutral	3.20	0.001

Climate scale (f4): interpersonal conflict (collected)	Medium	3.12	0.001
Community action: users are taught to control and express their emotions in appropriate ways and places	Quite	2.88	0.002
Community action: promoting mutual aid and sharing among users	Neither positively nor negatively	2.82	0.002
The staff acts as: a source of support and motivation	Neutral	2.82	0.002
Cluster 5. Disillusioned			
Item	*Mode*	*V-test*	*p-value*
The staff acts as: a source of support and motivation	Little	5.03	< 0.001
Interventions at the therapeutic community emphasize: community values	Little	5.03	< 0.001
Interventions at the therapeutic community emphasize: the development of individual responsibility	Little	4.65	< 0.001
Interventions at the therapeutic community emphasize: a sense of belonging to the community	Little	4.65	< 0.001
Interventions at the therapeutic community emphasize: the professionalism of the staff	Little	4.13	< 0.001
Interventions at the therapeutic community emphasize: the multidimensionality of interventions (medical therapy, psychoeducational interventions, etc.)	Little	4.06	< 0.001
The staff acts as: a behavioral model	Little	3.93	< 0.001
The problem the intervention must address is not the substance but the person	Quite disagree	3.82	< 0.001
Therapeutic community effectiveness: staff competence	Very little relevant	3.82	< 0.001
Interventions at the therapeutic community emphasize: participation in community life	Little	3.82	< 0.001

Note. Each cluster contains the 10 most representative items.

Chi-square analyses revealed a significant association between the clusters and gender ($\chi^2 = 15.96$, $p = 0.003$). The adjusted standardized residuals indicated that men were more likely to be associated with the "Professional Communitaries" cluster (adjusted standardized residual = 2.1) and the "Disengaged" cluster (adjusted standardized residual =

2.0), while women were more likely to be associated with the "Idealizing" cluster (adjusted standardized residual = 2.6) and the "Disillusioned" cluster (adjusted standardized residual = 2.0). No significant associations were found between the clusters and the participants' age ($\chi^2 = 6.70$, $p = 0.569$), education level ($\chi^2 = 8.67$, $p = 0.926$), geographic area ($\chi^2 = 60.15$, $p = 0.205$), length of service ($\chi^2 = 7.33$, $p = 0.501$), or weekly working hours ($\chi^2 = 9.89$, $p = 0.273$).

Discussion

The present study aimed to map the different organizational cultures within the Emmanuel community, operationalized in terms of symbolic universes, identifying the prevailing models of action and possible directions of development.

By combining multiple correspondence analysis and cluster analysis, five symbolic universes were mapped: I*dealizers, Self-referential, Professional Communities, Disengaged, Disillusioned*.

It emerges that for the *Idealizers* cluster, the community appeared to be fully aligned with the ideals of the participants, perceived as salvific and untouchable in its perfection. Within the relationships between operators, it can be hypothesized that when a critical issue arises, it may not be possible to consider the community itself as the object to be improved. Instead, the external world of the community was seen as the one that must change, in order to maintain the community as an entirely good object. If this were not the case, and there was the possibility of recognizing its fallibility, the risk would be to move from idealization to total devaluation.

The *Self-referential* cluster focused on the treatment model and the effectiveness of the community solely in terms of authority and behavior management. Treatment works if the patient follows the instructions given; rehabilitation is effective when educational actions focus on behavior. Other components, such as values, relationships, and sharing, appeared to be of little significance.

The *Professional Communitaries* cluster operated through a "maternage" approach, meaning the caregivers take responsibility for the patient. In this case, it seemed that the operator substituted for the community, and the relevance of daily activities as key elements for

rehabilitation fades in favor of personalization and the individual's growth and personal maturation.

The *Disengaged* cluster seemed to engage with the concreteness of events, adopting an evaluative perspective. They appeared to discern between the proposed elements but, at the same time, seemed unable to identify alternative solutions. It was as if they found themselves in a contemplative position, observing and evaluating without taking action.

The *Disillusioned* cluster seemed to have a "disillusioned" view of the phenomenon of "addiction" in a broad and general sense, as if the disillusionment and skepticism they experience are all-encompassing. It can be hypothesized that these individuals struggle to imagine solutions to problems, instead perceiving these problems as "obvious," an inherent part of the experience. Everything is experienced as "disillusioning." Therefore, both the identity aspect and the potential for integrative evolutionary growth are perceived within the same framework of meaning marked by distrust. It can be hypothesized that there is no space for potential change, as their actions are in relation to an object that will disappoint.

Thus, it emerges that, in the absence of governance, personal meaning resources are amplified to cope with the complexity of events, as meaning constitutes the experience by shaping reality. This plurality, which could become a critical issue if it persists without understanding, can be an evolutionary resource if managed with conscious awareness of the process. This process requires highlighting the constraints that influence meaning dynamics.

The exploration of the emerging segments allowed for the development of a sense-making framework for the Emmanuel community. What might initially appear as a plurality of cultures that are distant from each other, is actually a multiplicity of responses to the same evolutional issue; namely, the processing of grief related to the loss of the idealized object.

Indeed, the Emmanuel community system is in a phase of transition, moving from a charismatic model that has characterized its history, toward a network-based organizational structure that emphasizes the integrated autonomy of individual operational units. The weakening of the model that has guided the structure from its inception to the present, due to a variety of factors such as territorial expansion, professional development, social evolution, and relative autonomy, has

led to the consolidation of local cultures as a coping mechanism for the present moment.

The findings highlights how the absence of a sense of anchorage, which had been a resource for the Emmanuel community system – characterized by a sense of certainty regarding what was being done, why it was being done, and how it should be done, based on a value system that also served as a method – has led to the search for substitutes in the symbolic forms available. Specifically, it emerges that the group no longer produces the anchorage, but rather the context of belonging or personal characteristics. Symbolic universes describe how, on one hand, there is the rigidification of the previous anchorage, as seen in the *Idealizers* group with the risk of ritualization and loss of value, and on the other hand, in the anomie, we find the *Disillusioned*. The *Professional Communitaries* absolutize professionalism, while the *Self-referential* group extremizes the norms. Therefore, a complex articulation emerges, with a clear difficulty in sharing the logics of meaning for a common project.

The management of this process involves the consideration of three elements: organization, culture, and competence. The organizational aspect requires an initial phase of analysis of the practices in place, to define structures that foster certain more functional logics over others. Culture, in light of what has emerged, requires practices that promote the integration of the profiles outlined. Competence pertains to the promotion of shared criteria in the delivery of services. To promote the objectives outlined, the necessary devices are as follows: internal monitoring of activities, organizational analysis through the exploration of the micro-dynamics of the organizational process, training, and supervision of operators. These operations should become an integral part of activity management, thus integrating into the process with a governance perspective.

This study has some limitations that should be mentioned. The cross-sectional design of the study and the small sample size limit the generalizability of the results to the specific community under study. Future studies could be replicated on larger samples and considering different communities, to obtain detailed information on the functioning of communities on the Italian territory. The use of an online questionnaire may have induced a sampling bias, excluding personnel who do not have access to electronic devices. Finally, the use of a self-

report questionnaire could be susceptible to social desirability bias. Future studies could consider the integration of additional methodologies, such as semi-structured interviews and focus groups, in order to integrate a qualitative dimension in the study.

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Finding out Synergy between Organization and Subjectivity: introducing the SCOPRI Method

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Abstract

The integration of individual and organizational interventions, with a focus on well-being and effectiveness/efficiency, currently represents a key area of development within both psychological and managerial disciplines. We propose to reunite these elements, traditionally treated separately, through a paradigm of subjectivity conceived as the way individuals make sense of their relationship with the world, functioning both at the intrapsychic level and as a negotiated construction across contextual settings. Drawing on a comprehensive review of the scientific literature, we will introduce the SOS approach – *Synergy between Organization and Subjectivity* – also introducing an intervention method that allows the integration of six strategic dimensions: the SCOPRI Method – *Significances, Competencies, Organization, Processes, Relationships, and Image*.

Keywords: organization, subjectivity, culture, corporate development, performance, well-being at work.

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Introduction

Psychological and managerial disciplines have progressively valued the development of a perspective capable of integrating individual and organizational variables (Nielsen & Abildgaard, 2013; Tang *et al.*, 2024). These areas have often been considered separately in the past, with individual-level interventions focusing mainly on psychological health and organizational-level interventions focusing on optimizing processes and structures. However, the most recent scientific evidence shows that they are closely interconnected. Notably between job satisfaction and performance (Judge *et al.*, 2001; Schaufeli & Bakker, 2004), employee well-being and business results (Grawitch *et al.*, 2006; Harter *et al.*, 2003), organizational effectiveness, work performance, work engagement, and job crafting (Bakker *et al.*, 2012; van Wingerden & Poell, 2017; Zhang & Parker, 2019), employee satisfaction and market value of the organization (Edmans, 2012; Huang *et al.*, 2021), individual motivation, sustainability, and organizational performance (Lorincová *et al.*, 2019; Wang *et al.*, 2024).

While acknowledging the relationships between these dimensions, there is a tendency to approach them separately, with clear repercussions for both disciplinary integration and the design and implementation of interventions.

From this standpoint, the dichotomies individual/organization – well-being/efficacy seem to refer to the two opposing formulations of subjectivity: on one hand, the classical intrapsychic model, which represents it as rooted in the cognitive structures of the individual and isolated from the environment (Miller, 1956; Neisser, 1967); on the other, Vygotsky's formulation (1978), according to which higher mental functions emerge from socially mediated activities. Language acts as a mediating tool that transforms external processes of dialogue into internalized forms of thought. It is therefore not merely a tool for individual expression, but a social phenomenon in which significances and identities are co-constructed: inner speech is nothing more than a reflection of internalized social dialogue, just as subjectivity is an organizer of experience that is continually regenerated through interaction with others (Bruner, 1990; Salvatore & Venuleo, 2013).

Semiotic mediation, initially theorized by Vygotsky (1978), describes how every cognitive act is made possible and structured by the

use of signs which, in the cultural paradigm, do not simply function as passive labels, but play an active role in the development of mental processes and actions (Valsiner, 1997), also modulating emotional regulation through symbolic models of interpretation and regulation of affective states (Salvatore, 2018; Valsiner, 2014).

Within the traditional intrapsychic paradigm, higher mental functions – such as memory, planning, and emotional regulation – have been studied as processes internal to the individual, mediated by specific brain structures and cognitive schemas (Schacter & Addis, 2007). This approach has made useful contributions to the understanding of stress, coping, and psychopathology (Lazarus & Folkman, 1984; Maslach & Leiter, 2000), but it has failed to capture the relational dimension of subjectivity.

Analogous to language – conceived both as *inner speech* and as a shared social practice (Vygotsky, 1978) – subjectivity extends along a continuum from the private to the public, from individual interiority to interpersonal and institutional contexts (Linell, 2009). Indeed, Edwards and Potter's (1992) discursive psychology already supports a view of identity and emotions as emerging from the fabric of everyday discourse: not from stable cognitive structures but as situated linguistic practices. The distributed cognition approach (Hutchins, 1995) further expands this conception, showing how cognitive processes are distributed across networks: thought is not localized in the brain but manifests itself in interaction. The mind is thus represented as an ecological product, emerging from participation in social dynamics (Marková, 2003; Salomon, 1993).

As proposed by Salvatore (2013), mind and environment cannot be conceived as separate entities interacting with each other; rather, they are descriptive forms – on different space-time planes – of the same dynamic of signification. From this viewpoint, the self and the context are simply two sides of the same coin. This entails a radical shift in perspective: from viewing the ontological quality of the world as the foundation of experiential continuity, to recognizing that the continuity of experience itself underpins the embodied sense of the world's ontological subsistence. This paradigm of subjectivity has significant implications for both research and intervention. On the methodological side, it requires qualitative and quantitative approaches that analyze representations and narratives (Nicolini, 2013). On the

application level, it requires interventions that can act simultaneously at the individual and organizational levels, recognizing that subjective transformations only occur if supported by coherent social practices (Valsiner, 2007).

SCPT – Semiotic Cultural Psychology Theory (Cremaschi *et al.*, 2021; Salvatore, 2018; Salvatore & Venuleo, 2013) integrates cultural psychology and psychoanalysis, outlining a more general model of the relationship among mind, meaning, subject, behavior, and society, based on the psychoanalytic concept of subjectivity as an endogenous component of social action: the unconscious functioning of the mind is deeply intertwined with the organizational design, objectives, structure, and all the factors that determine the functional action of actors in the context. In this view, significance is not an intrinsic quality of the object, but rather the way of making specific elements of reality relevant by giving them meaning and making them emerge as contents of experience. Signification is therefore defined as *embodied*, since knowledge of the object does not consist solely in possessing a symbolic representation of it, but also in the propensity to enter a relationship with it through corporeality. Concepts and representations are therefore understood as patterns of bodily activation that are effectively comparable, from a sensorimotor standpoint to perception and movement. It follows that signification is a contingent process: it is continuously realized in the present moment, giving shape to a flow of signs whose significance is what happens in one of the infinite instants, what Salvatore and Cordella (2022) term the *instantaneous velocity of signification*. *Indexicality* refers to the principle according to which the semantic value of a sign is neither unique nor universal but is defined through its relationships with surrounding signs and their contextual combination (Sondheim, 1976).

The triadic nature of semiosis – in which the production of a new sign is based on the interpretative act of the previous sign – is intrinsically intersubjective[1], as it simultaneously involves two signs and

[1] Intersubjectivity (Mead, 1934) describes the process through which subjects co-construct significances, intentions, and mental representations in a context of mutual interaction. This is not an aggregation of individual points of view, but rather a dynamic common field in which the actions, perceptions, and interpretations of each

the subject who interprets them (Deely, 1990). Signification is also *situated*: it is present and definable in context, although it does not coincide with a mere phenomenal precipitate.

Considering the theoretical premises outlined above, affects can be considered signs of a global character, hyper-generalizing and homogenizing. Since every sign constitutes a response shaped by the interpretation of the sign that precedes it, affects also take the form of signs: they are neurophysiological responses which, based on the hedonic value attributed to them by the individual, interpret and represent the unfolding of the signs that generated them. Within this framework, organization acts as an intersubjective semiotic field which – thanks to its pre-reflective self-evidence – shapes the mental landscape of the actors and acts as both a condition and a form for the regulation of social action (Salvatore & Cordella, 2022).

The SOS approach – *Synergy between Organization and Subjectivity*

Considering the theoretical framework outlined above, we assume subjectivity to be both internal to the individual and distributed across relationships. It therefore represents the way in which we give significance to our relationship with the world; a significance that is both internal to the individual and socially constructed within and through the conditions of contextual environments.

This approach offers the opportunity to bring together the dichotomies of individual/organization and well-being/efficacy, transforming them into dialectical and circular relationships. In this respect, well-being can be represented as the capacity to regulate one's relationship with the world in an evolutionary way (Carver & Scheier, 2001), implying empowerment (Ryan & Deci, 2001) as a means and form of self-realization. It follows that well-being is empowerment (Fisher, 2008; Serino *et al.*, 2012) and is achieved through and in terms of empowerment (Cattaneo & Chapman, 2010; Perkins & Zimmerman, 1995; Rappaport, 1981).

actor are continuously negotiated, regulated, and reformulated through communicative channels and shared practices. In this perspective, the mind is not an isolated entity but develops and manifests itself through meaningful relationships.

On the other hand, efficacy requires the ability to invest in action (Locke & Latham, 2002; Ryan & Deci, 2000), which can only be actualized when the individual sufficiently identifies with that action (Sheldon & Elliot, 1999; Vallacher & Wegner, 1987), it as part of their conceivable horizon of well-being (Deci & Ryan, 2000). Well-being therefore requires effectiveness (Ryff, 1989), which in turn is conceivable if it is capable of developing well-being (Antonovsky, 1987; Bandura, 2006; Seligman, 2011). On a further level, to promote empowerment and well-being at the individual level – considering action as a relationship between the individual and the environment (Lewin, 1936; Ramstead *et al.*, 2016; Valsiner, 2014) – we benefit from the design of resource-generative environments (Antonovsky, 1987; Ryan & Deci 2000). In such environments, the potential to be generative is realized through the subjects who inhabit them (Engeström, 2001; Paniccia *et al.*, 2008; Patel *et al.*, 2017).

We refer to this as the SOS approach – *Synergy between Organization and Subjectivity* – which values the opportunity to conceive, design, and implement interventions aimed at individuals through organizations and vice versa, in a dialectical and generative exchange.

The SCOPRI Method

The SCOPRI Method – in italian, "*scopri*" means "find out" – offers a development perspective for the analysis, design, and implementation of interventions and services aimed at fostering and enhancing the synergy between organization and subjectivity. According to the SOS approach previously outlined, the SCOPRI Method offers the strategic opportunity to work in a way that generates a virtuous synergy between six dimensions: *Significances, Competencies, Organization, Processes, Relationships, Image*. This strategy is designed both for internal (employees, managers, stakeholders, etc.) and external (consultants, researchers, etc.) organizational actors, with the aim of developing organizational awareness and good practices within a systemic view of the organization.

These are the key points of the model we propose, which differentiates itself from other relevant proposals – such as Tavistock Model, General System Theory or Contingency Theory – while sharing and developing some of their assumptions.

Tavistock Model emphasizes the interdependence between social and technical subsystems within the organization, proposing the joint optimization of these systems as a universal goal (Govers & Van Amelsvoort, 2023; Trist & Bamforth, 1951). However, organizational life is inherently conflictual, as multiple perspectives and particular interests coexist within any organization. The mediation of such conflicts cannot be delegated to technical or regulatory interventions, which tend to focus primarily on the intra-organizational level, often neglecting the influence of institutional, cultural, and geopolitical factors that profoundly shape contemporary organizations. Effective mediation requires fostering dialogue among divergent positions in order to construct possible convergences by contextualizing conflicting viewpoints within the organizational processes and cultures of which they are an expression.

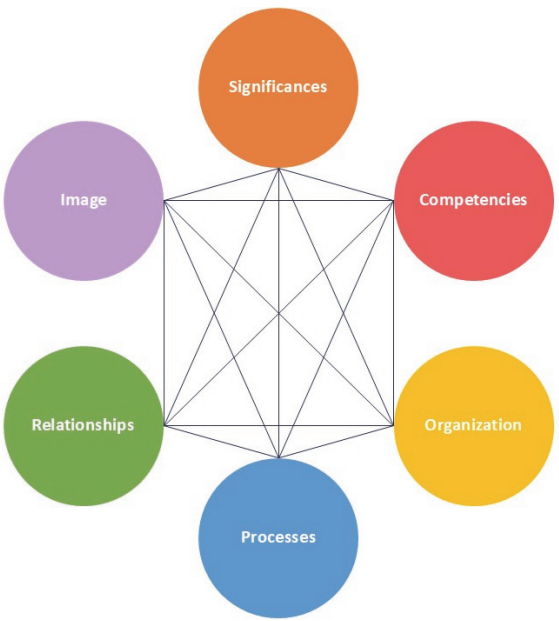
General System Theory provides broad concepts such as *interdependence*, *feedback*, *homeostasis*, but often at a level too theoretical and general to be directly applicable to organizational practice (Peery, 1975). This lack of specificity can make it difficult to translate into concrete management tools. It implicitly assumes a harmonious and self-regulating vision of systems, often neglecting the dynamics of conflict, inequality, resistance and power that run through real organizations. This can lead to an idealized and uncritical representation of organizational reality (Ulrich & Reynolds, 2010). Using critical events for development purposes requires considering them as sources of knowledge to be explored, developing organizational environments that can promote tolerance of uncertainty, cognitive openness, suspension of judgment and the competence to analyze and reflect. Furthermore, as already discussed, we consider organizations not only as functional systems but as symbolic and cultural constructions. General System Theory tends to neglect the subjective and symbolic dimension of organizational action, sometimes reducing social phenomena to mere input-output flows or regulation schemes (Meadows, 2008).

Contingency Theory posits that there is no single best way to organize. Instead, organizational effectiveness depends on the *fit* between internal structures and external environmental conditions (Donaldson, 2006). It also assumes that the environment largely determines organizational structure and functioning, taking risk of underestimating the strategic, interpretative and transformative capacity of organizational

actors, reducing the organization to a passive entity that adapts to external conditions (Child, 1972; Donaldson, 2006). Similarly, the model focuses on structural variables (technology, size, environment), neglecting the role of organizational cultures and shared meanings, elements that are today central to understanding the functioning of complex organizations. Furthermore, the theory relies on identifying *fits* between relatively stable variables, but in environments with high uncertainty, turbulence or ambiguity, such as digital or post-pandemic environments, conditions change too rapidly for the model to be applied effectively.

Considering this scenario, we provide below an overview of the six dimensions composing SCOPRI Method, conceiving them not as hierarchical or sequential, but rather from the systemic perspective, as illustrated in Figure 1. We will propose some points for reflection on resources, critical issues and possible scenarios, without aiming to provide an exhaustive account which may be explored in greater methodological depth in future studies.

Figure 1. *Graphical representation of the SCOPRI Method*



Significances

Significance is a dynamic and relational construct. It mediates the relationship between the subject and the world (Salvatore, 2018): as a lens shapes and constrains what an individual sees, not generating it but defining its form, so the representation of reality occurs according to the significance attributed to it.

Furthermore, returning to Peirce's principle of the triadicity of the sign (1935), significance resides in the capacity of a sign to elicit a response in the interpreter, that is a further sign that establishes the relationship with the previous one. The sign, therefore, is not limited to the relationship between a signifier and the object to which it refers but implies a third element: the interpretative function of the interpreter (Salvatore *et al.*, 2019). Consequently, significances emerge from an infinite semiotic chain, within which «*each element is simultaneously the interpretation of the previous sequence, its realization in the present moment, and the elicitor of the next sign, which projects the sequence forward in time*» (Salvatore *et al.*, 2019, p. 216).

Geertz (1973) had already proposed considering culture as a system of significances. Moscovici (1984) introduced the concept of *social representations* to denote shared significances systems that influence perceptions and actions. These significances systems – or cultures – are formed, transformed and spread through everyday communication: they do not reside in the individual mind, but in the co-constructed intersubjective field. Significances then evolve with the child's development, who internalizes cultural tools – such as stories, games, rules – transforming them into mental structures that guide thought, emotion, and action (Cole, 1996; Luria, 1976).

According to semiotic-cultural psychology, affective signs ground and shape generalized significances that underlie the way human beings make sense of their being in the world, generating one vision rather than another. Such systems are latent global beliefs about self and reality, recognizable only indirectly through cognitive and pragmatic outputs (statements, evaluations, actions on specific issues) (Salvatore *et al.* 2019). Significances thus represent the way actors interpret the context. This system of significances, which is not necessarily explicit and recognized, structures the logic of value construction in terms of which organizations configure their actions, giving significance to

their relationship with the environment, strategies, methods, and operating modes (Salvatore, 2016).

Organizations are therefore action systems oriented by cultures, understood as generalized systems of significances that organize thought and action. From this perspective, subjectivity is a self-referential dynamic, prone to blind self-reproduction without stopping even in the face of potentially destructive scenarios. Even if the information available about the environment is cognitively grasped, this is not enough to change meaning systems. On the contrary, most of the time these systems assimilate information, paradoxically transforming it into nourishment for their own premises. Von Bertalanffy (1968) already pointed out that every organization preserves its identity through processes of exchange and regulation with the external environment. In this sense, Salvatore (2016) speaks of self-referentiality rather than self-preservation, concluding that merely recognizing the consequences of one's evaluations is not sufficient to change the affective scenario that fed them.

For this reason, especially in organizational interventions, working on significances is more effective than focusing solely on individual variables and behaviors (Valsiner, 2007). Furthermore, since significances are reproduced through interactions, any evolution of such systems – for example, the adoption of new models of work or well-being – requires symbolic renegotiation within the organizational community (Hall, 1997).

Competencies

According to the contemporary perspective on learning and professional action, competencies are not seen as intrinsic qualities of the individual, but rather as criteria for action distributed across the contexts in which practices take place (Hutchins, 1995; Nerland & Jensen, 2014). We therefore assume competence as a cultural model for interpreting the relationship with the environment, which underpins the actor's purposive capacity (Salvatore, 2016). It requires the coherent and profitable orchestration of internal – cognitive and affective – and external resources (Pellerey, 2004).

Scientific literature draws an important distinction between skills

and competencies. The former are traditionally understood as specific operational and technical abilities, acquired through practice and repetition and typically assessable in isolation, through standardized exercises or objective tests (Spencer & Spencer, 2008). However, as early as 1995, Hutchins expanded the notion of skill to include the capacity to orchestrate material and collaborative resources, operating and distributing them among individuals and tools.

On the competence side, Billett (2001) documents how they are formed through participation in organizational activities, where artifacts, rules, and division of labor distribute criteria for action among group members. They are therefore individual and situated, developing through active involvement in real social activities (Lave & Wenger, 1991). Eraut (2004) highlights the emergence of skills in the flow of everyday action, arguing that they cannot be reduced to lists of skills. This is particularly visible in work contexts, where situational awareness guides the choice and integration of skills according to the objectives, resources, and constraints. For example, a candidate may demonstrate strong quantitative reasoning skills in a psychometric test but show poor competence if they are unable to negotiate shared solutions with the work group or interpret incomplete data in the business context (Fleishman, 1975; Spencer & Spencer, 2008).

In this regard, Tardif (2006) proposes the use of authentic assessment tools – portfolios, in-situ observations, reflective interviews – since reduced-content tests, or skill tests cannot capture the ability to orchestrate resources in real situations. Whereas skill is measured by the accuracy and speed of operations, competence requires metacognitive integration and application in complex contexts (Schoenfeld, 2016). Consequently, the design of learning and development contexts becomes crucial: they must offer authentic problems, multiple resources, support for reflection, and opportunities for social negotiation to foster competence development (Jonassen, 1999). This necessarily entails a shift in focus (Mulder *et al.*, 2007): from teaching skills (instructions, isolated technical exercises, tutorials) to accompanying and supporting the emergence of competence through reflective, project-based, and community practices.

Organization

Organization is the way in which a certain system of action defines, maintains, and adaptively regulates its relationship with the environment (Engeström, 1987; Valsiner, 2014). In this way, this relationship is regulated through cycles of interpretation and action that allow meaning and order to be derived (Weick, 1979). In addition to ordinary generalizations, organization includes hyper-generalization, affective fields of meaning capable of guiding action in novel contexts, enabling the system to anticipate possible scenarios and regulate itself in unpredictable situations while preserving internal coherence. It follows that organization is not a given fact, but a continuous process of semantic autopoiesis[2], in which the system constantly redefines its own rules and tools in response to contradictions emerging with the environment (Valsiner, 2014).

Organizational forms are therefore not simply containers for activities but participate – directly or indirectly – in determining the capacity and methods for successful action. This generates particular forms of dialectic between action and environment, historically analyzed by organizational thinking and management theory through two divergent paradigms (Aldrich, 2008; Bonazzi, 1999; Braun *et al.*, 2012; Rogelberg, 2007; Salvatore *et al.*, 2019): on the one hand, the action-centered regulation model, and on the other, the environment-centered regulation model.

Action-centered regulation is based on the idea that it is the constraints and operating conditions of the activity that define the regulatory framework within which the organization interacts with the (internal and external) environment (Maturana & Varela, 1980; Stewart, 2000). This translates into placing the entire production process and the technical constraints that determine its effectiveness at the center: technical specifications, standardized procedures, expected output levels. The individuals involved, both inside and outside the organization, are represented functionally according to production needs, assuming the

[2] Semantic autopoiesis is an extension of the concept of biological autopoiesis (Maturana & Varela, 1980) which includes not only the capacity of a system to self-produce and maintain its own organization, but also to self-define and self-regulate a symbolic domain endowed with causal efficacy in the dynamics of the system itself (Stewart, 2000; Valsiner, 2007).

role of resources to be optimized in terms of efficiency and operational performance (Taylor, 1911). The value of an action is therefore defined by its ability to meet internal standards of technical quality, cost, and time. These measurable criteria guide decision-making and control practices, reducing organizational complexity to quantifiable elements (Simon, 1947). As a result, elements such as social or environmental externalities and the perceived usefulness to the end user are not included in the assessment of organizational success. As an example, consider a production model in which concrete operating principles (setup times, inventory levels, line quality) serve as the sole normative criterion: the rules – and their verification system – arise directly from the need to maintain constant, waste-free production flows. A further example of this model is "*technicality*" (Carli & Paniccia, 1999), understood in both a conceptual and operational sense, which takes as its normative criterion for the relationship between action and environment the technical parameters that regulate the expert's activity.

Environment-centered regulation reversed this logic: action no longer defines the rules but is shaped by the characteristics and stimuli of the environment (Lawrence & Lorsch, 1967). In this view, organizational actors are guided by an external constraint, while resource allocation and strategic decisions are aimed at maximizing the capacity of action to conform to environmental demands (Thompson, 2003). The parameter for success is therefore the alignment between operational practices and environmental constraints, rather than mere compliance with internal standards. In these organizations, it is the boundary functions – such as marketing and sales – that play a crucial role. These departments are responsible for constantly monitoring critical external variables (market demand, regulations, competitor actions) and, based on this information, defining the criteria that guide the entire organization. This does not mean completely neglecting internal requirements: these remain relevant, even if they do not prescribe action but define the best possible adaptation to the environment. As an example, consider an organization that bases its governance on the demands of consumers, communities, and institutional stakeholders, integrating environmental metrics (CO_2 emissions, water use) and social metrics (working conditions in the supply chain) into the decision-making process. The success criterion is the satisfaction of external standards defined at the macro-organizational level.

These two paradigms propose a static model of the relationship between action and environment, opposite instantiations of the same interpretative framework, which precludes the identification of effective solutions when there is no possible compatibility between the demands of the action and the modalities in which the environment presents itself. Action-centered regulation and environment-centered regulation share the assumption that, in order for interaction to be possible, one of the two components must assume a dominant and binding position over the other, in order to ensure their mutual compatibility. This makes the relationship inherently conflictual and asymmetrical. The dynamic model (Salvatore *et al.*, 2019) offers an alternative to this static conception of the relationship between action and environment, providing an interpretative and methodological framework for devising value-creation strategies in contexts characterized by critical levels of turbulence. This model is characterized by three core dimensions: it is evolutionary (it considers the characteristics of the contractors as a function of the exchange between action and environment – they evolve together, through and because of this exchange), recursive (it considers the characteristics of the contractors and the interaction between them as simultaneously cause and effect of each other) and dialectical (it considers possible synthesis not as a search for common ground between thesis and antithesis, but as a higher-order solution capable of capturing and developing both, enhancing their mutual otherness). By way of example (though not exhaustively), for organizations, regulating the relationship with the environment in a dynamic way is possible through certain methodological criteria: strategic vision, by modulating daily behavior based on the interpretation of contingent events within the medium-term temporal and semantic horizon in which strategic objectives are pursued; incrementalism, by valuing the construction of the relationship with the environment as the result of a recursive evolutionary process, fueled by the ability to use the results achieved as subsequent inputs; compatibility, by assuming the relationship between action and environment as cooperation between mutually autonomous subjects, valuing the search for perspectives that are sufficiently abstract to be shared by each of the actors; perspectivism, by recognizing the project of environmental stakeholders, their core identity, as a non-negotiable aspect but also as a perspective of meaning and an evolutionary lever for exchange.

Processes

Processes emerge from the situated interaction among everyday practices integrated by shared significances, evolving in accordance with the environment (Orlikowski, 1996; Pentland & Feldman, 2005). The process is therefore the smallest unit of dynamic relationship between meaningful activities, intertwining the ostensive aspect (the ideal form) and the performative aspect (the concrete execution of the activity) (Cremaschi *et al.*, 2021; Feldman, & Pentland, 2003).

Although by definition abstract, taking the form of a network of relationships between effects (Beer, 1979), the process is also a concrete fact with decision-making and symbolic implications, as it attributes value and functional meaning. As an example, consider a company that is in the process of marketing a new product: clarifying whether the process in place is driven by financial profit rather than by building customer relationships will generate radically different positions and practices. In this sense, the organization defines – and proposes – its identity by mapping and prioritizing, explicitly or implicitly, certain processes over others (Gioia *et al.*, 2013; Hatch & Schultz, 2002; Krücken & Meier, 2024; Pratt *et al.*, 2016).

It follows that reorganization of processes is an operational aspect that concerns procedures, but above all an element of strategic importance. Consider the radical difference between a customer-oriented organization and a service-oriented organization. The former will take as its normative criteria the preferences and behaviors of the customer, considered as a fundamental corporate asset. Organizational success will consequently be measured through indicators such as customer satisfaction ("*The customer is always right!*"), wallet share, and propensity for positive word of mouth (Griffin, 2002). In contrast, service orientation proposes a vision of the product as a process co-constructed in the interaction between provider and user, who is represented as a partner in the production process, transforming customer dependence into a lever for generating value (Norman, 1986; Vargo & Lusch, 2004). Success is evaluated in terms of perceived quality and the company's ability to orchestrate tangible and intangible resources when needed (Grönroos, 2015).

Organizations constitute autonomous entities thanks to the human fabric that animates them. This inherently implies the challenge of survival when that fabric becomes rigid or breaks. This apparent contradiction reflects the paradoxical nature of organizational systems: on the one hand, they emerge from daily interactions between individuals, who together generate significances and interpretations that shape organizational identity, shaping shared roles, norms, and cultures (Maitlis & Christianson, 2014; Weick, 1979); on the other hand, they develop structures and procedures that can overload or conflict with individuals, imposing constraints that transcend individual will (Feldman & Pentland, 2003; Vaara, & Whittington, 2012). In this sense, organizations can be seen as parts of vital worlds lent to a purpose and constantly oscillating between two extremes: total assimilation into vital worlds and full incorporation of the organization's abstract purpose.

Both scenarios are doomed to failure. On one side, this dynamic opens the door to the perverse use of the organization for reproducing vital worlds, thus becoming a place of interpersonal conflict. Take, for example, family businesses or moments of generational transition within a company. Lansberg (1999) showed how personal and family dynamics (favoritism, expectations of loyalty, etc.) can shape company procedures, generating interpersonal conflict between members of different generations or between founders and external managers.

On the other side, there is a risk of impoverishing the "warm" dimension of subjective engagement in the organizational context, in a fantasy of hyper-rationalization that necessarily pits subjectivity against rationality. Consider the extreme rationalization of work activities through the breakdown of tasks, the study of times and movements, and the standardization of methods (Taylor, 1911). In this view, production efficiency becomes the absolute normative criterion, to the detriment of the subjective and relational dimension of work, fragmenting the production process into elementary operations regulated by mechanical procedures.

The growth of organizations therefore lies in their ability to configure themselves as intermediate processes (Cremaschi *et al.*, 2021): a social-practice context founded on meaningful interpersonal bonds, organized around the pursuit of meta-interpersonal (almost universal) goals, rather than according to self-referential logics. This allows

subjectivity to be put into practice, while at the same time finding opportunities for elaboration thanks to the meta-interpersonal purpose. Consequently, in an intermediate context, the representation of the systemic dimension of organizational life integrates with individual subjectivity, acquiring personal connotations. By placing itself in a position to operate in an intermediate dimension, the organization can increase its possibilities for growth, allowing individuals to experience the system as a concrete and meaningful entity in their existence.

Image

Organization's image plays a fundamental role in determining how the environment – customers, suppliers, employees, institutions, local communities – relates to the organization itself (Cornelissen, 2004). More precisely, it is not so much the internal reality of the company that shapes external expectations, but rather the perception that the environment develops on the basis of visual, narrative, and behavioral signals: brand identity, sustainability reports, communication campaigns and the behavior of senior management (Abratt & Kleyn, 2012). This attribution process is based on two main mechanisms. First, selective amplification: the public tends to pay attention to those elements of the image that confirm their prior expectations, thus creating a *reputational echo chamber* (Hatch & Schultz, 2008). Second, the phenomenon of social legitimation: an organization gains credibility and trust to the extent that it aligns its image with the values and norms of its context (Deegan, 2019; Suchman, 1995). From a managerial point of view, this calls for reflection on two types of intervention. The first concerns strategic alignment between internal culture and external identity: it is not enough to communicate an attractive positioning if the system of operating practices does not embody its values (Hatch & Schultz, 2008; Rohmanue & Jacobi, 2024). The second involves proactive image monitoring through data and insights obtained by continuous tracking, which serve both to detect in a timely manner any divergences between stakeholder perceptions and organizational intentions and to optimize decision-making processes, thereby enhancing the organization's capacity to adapt to crises and sudden changes (Cornelissen, 2004; Nuortimo *et al.*, 2024).

Ultimately, image is not simply a mirror of the organization but rather an interpretative filter through which the relationship with the environment is enacted and developed into a circular process. Consciously managing this filter means safeguarding the company's ability to attract relational capital and maintain its legitimacy over time. In this sense, image is not only what is represented but also the structure of representation that determines the evolutionary conditions and possible forms of representation of the organization. For example, through narrative analysis of user-generated social content (posts, videos, reviews), a beauty company can identify recurring archetypes (healing, empowerment, etc.) to be leveraged through marketing, making the brand an integral part of individual stories (Schroeder & Borgerson, 2020). Similarly, consider a company that does not merely sell products but offers usage scenarios and aspirational significances: customers engage not to purchase an object but to experience a value-laden narrative (Schmitt, 1999).

Implications for intervention and professionals

In scientific literature and professional practice, significances, competencies, organization, processes, relationships and image generally operate separately from one another, even though their various interconnections are recognized. This occurs in research as well as in the analysis, design, and implementation of organizational interventions.

Within the SOS approach – *Synergy between Organization and Subjectivity* – which promotes the generative value of the organization-subjectivity dialectic, the *SCOPRI* Method highlights the coexistence of *significances, competencies, organization, processes, relationships*, and *image* in the structure and development possibilities of organizational contexts. This makes it pertinent and relevant – albeit in a modulated way – to activate scenarios that could integrate these dimensions.

By way of example, below are some possible scenarios for intervention using this methodology, highlighting the dimensions directly involved and assuming the others as conditions, resources, and implicit beneficiaries. Consider the value of an organizational intervention capable of promoting and enhancing the exploration of corporate

image as a way of activating reflective processes on organizational culture and ways of relating. This would allow for integrated intervention on image, significances, and relationships, necessarily involving the redefinition and development of competencies, processes, and organization. In this perspective, the analysis of processes in interaction with the development of competencies – which vary in relation to process dynamics (Argyris & Schön, 1978) – as well as the revision of the organizational design to reorient the culture.

There are therefore many opportunities for the proposed synergy, which is capable of activating a virtuous cycle between the dimensions at play.

A further advantage, relevant to professional practice, concerns the possibility of attributing value to psychological intervention in the organizational environment. In this context, psychological intervention has historically focused on the use of psychometric tools for recruitment, performance evaluation and climate analysis (Cascio & Aguinis, 2011). Although these methodologies provide objective and repeatable data, exclusive reliance on tests and questionnaires risks limiting psychological action to a merely diagnostic level, neglecting the dynamic dimension of subjective and organizational processes (Spector, 2021). This results in a fragmentation of discipline and intervention, in which competencies, motivations, and relationships appear isolated rather than integrated into a broader organizational development plan. On the contrary, the synergistic perspective outlined above is achieved through the implementation of co-constructed interventions with a transformative perspective which – while also taking advantage of psychometric resources – represent the user as a strategic partner.

Concluding remarks and future directions

In a world characterized by rapid technological evolution, growing organizational complexity, and high social, environmental, economic, and political uncertainty, companies – and professionals – tend to move increasingly toward strengthening efficacy and efficiency, valuing performance through indices and methods that nevertheless risk

marginalizing the human factor. On the contrary, the review and proposition advanced in this paper argue for the importance of strengthening organizational structures by reclaiming the value of subjectivity within and across organizations. With the presentation of the SOS approach – *Synergy between Organization and Subjectivity* – and the articulation of the SCOPRI Method – *Significances, Competencies, Organization, Processes, Relationships, Image* – we propose an integrated perspective capable of reconciling well-being and performance in a continuous dialectical exchange, overcoming the traditional dichotomy between organizational and individual interventions. From a theoretical point of view, the subjectivity paradigm serves as a unifying element between intrapsychic dimensions and the environment, highlighting the co-construction dynamics of meaning.

In strategic terms, the SCOPRI Method offers a way to generate virtuous synergy among the six dimensions: significances, competencies, organization, processes, relationships and image. This synergy allows the alignment of corporate mission and vision with the expectations and values of members, external stakeholders and the environment, fostering (Kahn, 1990) a climate of trust and participation at the basis of job crafting (Petrou *et al.*, 2012). This also becomes a tool for employer branding and identity cohesion, generating value and capacity for the organization to attract talent, reduce turnover, and improve its overall reputation (Moroko & Uncles, 2008).

Although based on a review of scientific literature, this approach requires experimental implementation in organizational contexts that are able to challenge themselves with this ambitious and resourceful proposal. Longitudinal studies could also be useful to validate the predictive capacity of the SCOPRI Method's dimensions against indicators such as turnover, engagement, and productivity, as well as for examining their moderating effects during phases of digital transformation, generational transition, or organizational crisis management. Furthermore, the flexibility of the SOS approach opens up possibilities for integration with emerging approaches such as organizational ambidexterity[3].

[3] Organizational ambidexterity is the capacity of an organization to simultaneously pursue two seemingly opposing strategies: exploitation, namely the optimization and refinement of existing competences and processes, and exploration, that is

In conclusion, the complexity of the topic at hand and the current organizational context offer an opportunity to find new syntheses and strengthen structures through the human factor. This is not merely a slogan, but a strategic advantage for organizations.

The SOS approach – *Synergy between Organization and Subjectivity* – and the SCOPRI Method – *Significances, Competencies, Organization, Processes, Relationships, Image* – provide a compass for guiding organizational interventions capable of combining well-being and performance. Investing in significances, competencies, and relationships means building more agile, resilient and cohesive organizations, in which efficacy and efficiency emerge not at the expense of, but through, the full enhancement of human capital.

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the search for new opportunities, innovations, and radical changes (March, 1991). This dual approach is crucial in contexts characterized by rapid technological change and increasingly volatile markets, where organizations must maintain operational efficiency without sacrificing their capacity to adapt and renew themselves (O'Reilly & Tushman, 2004). Empirical evidence suggests that organizational ambidexterity is positively correlated with innovative and financial performance, as it allows companies to exploit the advantages of routine while exploring new market frontiers (Raisch & Birkinshaw, 2008). However, achieving a balance between exploitation and exploration is challenging: it requires investment in human capital, continuous learning processes, and effective coordination mechanisms to prevent conflicts and organizational overload (He & Wong, 2004; Wang *et al.*, 2023).

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Hospital Psychology Services: Representations of structural and functional changes

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Abstract

This study explores the evolution of Hospital Psychology Services (HPS) over the past decade, analyzing how professionals represent structural, functional, and managerial changes. Grounded in Semiotic-Cultural Psychology Theory (SCPT), the research employs Automated Co-occurrence Analysis for Semantic Mapping (ACASM) to examine interview data from 27 Italian HPS. Four themes emerged: *Organizational complexity*, *Organizational*

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challenges, *Service networking*, and *Service consolidation*. Results reveal bipolar semantic structures organizing these representations, notably *Professional practice vs Networking* and *Challenges vs. Empowerment*. The study provides a first overview of how the representational world of hospital psychologists can serve as a marker of the transformations taking place in the sector.

Keywords: Hospital psychology services, healthcare transformation, cultural analysis, representations, ACASM.

Introduction

Hospital Psychology Services (HPS) have become an essential component of modern healthcare systems, providing psychological support to patients, family members, and healthcare professionals. Their role has evolved from a marginal and primarily diagnostic function to an integrated clinical-therapeutic approach, establishing them as a fundamental pillar in managing the emotional aspects of illness and improving quality of life in clinical settings (de Lima, 2024; Wahass, 2005). This transition has been influenced by multiple factors, including changes in health policies, technological innovations, and emerging needs from both users and healthcare providers (Kidd & Styron, 2020; Runyan, 2011).

Over the past decade, the field has undergone particularly significant transformations at structural, functional, and managerial levels. The introduction of telepsychology and digital platforms has redefined service delivery models, improving accessibility while simultaneously presenting new organizational and ethical challenges (Rutkowska, 2022). Concurrently, increased attention to the psychological well-being of healthcare workers – amplified by the COVID-19 pandemic (Greenberg *et al.*, 2020) – has led to enhanced internal support services and the need for more flexible organizational models (Dülsen *et al.*, 2020).

These shifts are part of broader systemic changes in healthcare, including the digitalization of services, decentralization of care pathways, and a growing emphasis on patient-centered and value-based healthcare models (Porter & Lee, 2013; Topol, 2019). As hospitals

transform into complex, integrated systems, psychologists are called to redefine their roles beyond the traditional clinical encounter, engaging in care coordination, risk assessment, and prevention strategies across settings (Cummings *et al.*, 2017).

Another key transformation involves the expanding role of hospital psychologists, who are increasingly involved in decision-making processes and health policy development (Baker *et al.*, 2008). This evolution reflects the need for a holistic approach to health, fostering multidisciplinary collaboration and integrating psychological perspectives into daily clinical practice (McGinty, 2023; Engel, 1977). Such integration is particularly relevant in addressing complex challenges such as health inequalities, chronic illness management, and mental health comorbidity, where psychological expertise contributes significantly to improving outcomes and reducing system burdens (Hofmann *et al.*, 2012; Hunter *et al.*, 2017).

However, the growing demand for psychological services has also highlighted critical issues, including shortages of specialized personnel, the need for practice standardization, and disparities in service access (Dülsen *et al.*, 2020; Fava & Tomba, 2009). These systemic issues raise questions about how professionals perceive and adapt to institutional constraints, evolving roles, and shifting expectations, making it essential to understand not only what changes are occurring, but how these are represented and negotiated within the professional culture of HPS.

Against this backdrop, it is crucial to examine how HPS represent these changes and the semantic structures that organize such representations. Semiotic-Cultural Psychology Theory (SCPT; Salvatore *et al.*, 2016) provides a suitable theoretical framework for exploring these processes by conceptualizing psychological functioning as a meaning-making activity grounded in culturally situated and affectively charged assumptions (Valsiner, 2007). According to this perspective, representations of change in HPS can be analyzed as themes emerging from bipolar semantic structures, where the presence of one pole implies the absence of its opposite (Salvatore, 2016).

This study investigates these dynamics through a textual analysis of responses from HPS professionals to an open-ended question about structural, functional, and managerial changes over the past decade. The research has a dual aim: first, to identify how services represent

these changes; and second, to explore the semantic structures organizing such representations. Using a quali-quantitative approach based on the Automated Co-occurrence Analysis for Semantic Mapping (ACASM) method (Gennaro & Salvatore, 2023), the study seeks to provide an in-depth understanding of the challenges and opportunities shaping the evolution of hospital psychology in contemporary healthcare. By doing so, the research aims to inform academic debates as well as actionable recommendations for service planning and policy development, supporting more responsive and sustainable models of hospital-based psychological care.

Theoretical framework

The present study is based on the Semiotic-Cultural Psychology Theory (SCPT; Salvatore *et al.*, 2016; Valsiner, 2007), which conceives psychological functioning as a process of signification based on systems of generalized and affect-laden assumptions (Salvatore *et al.*, 2024). These systems of assumptions are influenced by the cultural and social environment in which individuals are embedded, while at the same time contributing to its structuring (Cole, 1998; Valsiner, 2007).

According to this perspective, the representation of a specific object or event (e.g., HPS) is configured through a coherent model of meaning, which SCPT defines as a "theme". This concept emphasizes certain characteristics or qualities of the represented object/event, relegating others to the background. Furthermore, SCPT postulates that representations are supported by semantic structures, which are comprised of bipolar basic components (Salvatore *et al.*, 2024).

Bipolarity is an essential aspect of semantic components, as the presence of one polarity implies the absence of the opposite meaning. Consequently, a theme is configured in terms of the presence or absence of the qualities that the semantic components make salient (Salvatore, 2016).

Method

Sample

The present study was conducted between October 2024 and March 2025 and involved a sample of HPS in Italy. To this end, the research team contacted 52 services by email, explaining the objectives and aims of the research. Of these, 27 agreed to participate after authorization from the manager, corresponding to a response rate of 51.9%. Of these, 16 services were located in Northern Italy, 7 in Central Italy, and 4 in Southern Italy.

Participation involved taking part in a semi-structured interview lasting about two hours. The semi-structured interview was designed to collect detailed information across four thematic areas: (a) systemic relationships between HPS and the hospital environment, (b) user profiles and service demand, (c) functions and activities of the services, and (d) organizational structures and management practices. Each thematic area included specific parameters explored through both closed questions and open-ended prompts (e.g., evolution of the hospital container, target of interventions, strategic relevance of functions, organizational learning processes).

The general objective of the interview was to reconstruct the evolution of HPS by capturing professionals' perspectives on structural, functional, and managerial changes as well as their impact on service delivery and professional roles. To this end, the semi-structured interview involved the psychologists serving as managers of their respective HPS.

This study focuses on the analysis of responses to a specific open-ended question, which asked participants to "reconstruct the significant structural, functional, and managerial changes that have occurred in the hospital psychology service over the past 10 years, with particular attention to the type of change, its timing, and the dynamics that generated it".

The choice to analyze this question was guided by its centrality in exploring the semantic representations of change within HPS, which is consistent with the study's aim of investigating the meaning-making processes underlying the evolution of hospital psychology services.

All participants provided informed consent after receiving a

detailed explanation of the study objectives. The research obtained the approval of the Ethics Committee for Research in Psychology (CERP) of the University of Salento and was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki, as adopted by the World Medical Association (WMA) during the 18th General Assembly (Helsinki, 1964) and subsequently updated at the 64th General Assembly (Fortaleza, 2013).

Data analysis

To identify emerging themes and the semantic structure of the textual corpus, the interviews were transcribed and subsequently aggregated into a single corpus. The data analysis was conducted using the Automated Co-occurrence Analysis for Semantic Mapping (ACASM) procedure (Gennaro & Salvatore, 2023; Salvatore *et al.*, 2012, 2017), implemented using T-Lab software (Lancia, 2004).

ACASM is divided into two phases. In the first phase, the corpus is segmented into elementary context units (ECUs), consisting of sequences of adjacent expressions. Each ECU begins immediately after the end of the previous one and ends with the first strong punctuation mark (".", "!", "?") that appears after a threshold of 250 characters. If an ECU exceeds 2000 characters, it is interrupted with the last word available within that limit, regardless of the presence of punctuation marks.

Subsequently, the text is subjected to lemmatization, a process that reduces the different lexical forms of a word to their common root (for example, "see", "seeing" and "seen" are all associated with the lemma "see"). Then stop-words and other words with no distinctive semantic content are eliminated, such as logical connectives ("that is", "in fact"), conjunctions ("and", "this"), auxiliary verbs ("to be", "to have") and the 5% of the most frequent lemmas, in order to reduce noise and optimize the analysis. This selection produced a subset of 300 most representative keywords, ensuring a balance between computational feasibility and the ability to identify significant patterns in the data.

In the second phase, the data underwent multidimensional analysis, which integrates cluster analysis (CA) and correspondence analysis

(COR). Through CA, groups of lexemes that tend to co-occur within the same text segments (ECUs) are detected, which are then interpreted as indicators of a specific theme. In other words, CA groups words using their presence in the same paragraph as a similarity criterion, and paragraphs are in turn grouped based on whether they share a similar pattern of co-occurring lemmas. The ACASM procedure adopts unsupervised K-Means as the clustering method, and the number of clusters to be selected is determined by inspecting the Calinski-Harabasz index (Caliński & Harabasz, 1974), the Davies-Bouldin index (Davies & Bouldin, 1979) and the intra-cluster correlation coefficient (ICC) of the various cluster partitions extracted from the CA. High values of the Calinski-Harabasz index and ICC and low values of the Davies-Bouldin index are considered indicative of good clustering. The interpretation of clusters, and therefore the identification of themes, is conducted by the research team through a consensus procedure (Harris *et al.*, 2012; Schielke *et al.*, 2009) and is based on the ECUs which are characteristic of each cluster and the combination of words that tend to co-occur within each ECU.

The COR breaks down and reorganizes the relationships between lemmas within a multidimensional factorial space in which each dimension is composed of two polarities. Each polarity is characterized by a set of lemmas that tend to co-occur and by the fact that, when they are present, another set of lemmas is absent (those of the opposite polarity). The multidimensional factorial space emerging from the COR lends itself to be interpreted in terms of the semantic structure of the text, with each factorial dimension representing a semantic component of this structure. Furthermore, COR extracts an estimate (expressed through factor scores) of the association between the factor dimensions and their characteristic lemmas. These estimates are used to interpret each polarity of the extracted factorial dimensions (Table 2).

Results

The analysis was conducted on a matrix composed of 66 ECUs and 300 lemmas. Cluster analysis (CA) extracted four clusters as an optimal partition, based on the quality indexes of the clusterization (Calinski-Harabasz = 3.55; Davies-Bouldin = 1.46; ICC = 0.15).

Based on the ECUs characteristic of each cluster and the co-occurring lemmas within each ECU, the research team interpreted the clusters as follows:

Cluster 1: Structural complexity. This cluster captures the structural and management transformations that have taken place over the last decade, with particular emphasis on the impact of the COVID-19 pandemic. Terms such as "COVID", "complexity", "model", "university" and "increase" indicate significant challenges related to organizational reconfigurations, critical issues and evolving institutional roles. The presence of terms such as "important", "clearly" and "type" suggests a discourse focused on defining the nature and extent of these changes, particularly in the academic and healthcare sectors. The most representative ECUs of this cluster were:

The gradual shift from a **consulting model** to an integrated, multidimensional, multi-proportional intervention **model**, integrated with the various areas and departments of the hospital, and **clearly** the **complexity** and subsequent **increase** in the number of people, etc., has led to an **increase** in activity, the presence of more people has **obviously** not only increased **complexity**, but also generated some **critical issues** in some cases, if you do little, you are less likely to do anything.

*[il progressivo superamento del **modello consulenziale** ad un **modello** invece di intervento integrato, multidimensionale, multi proporzionale, integrato con i vari ambiti, reparti dell'ospedale, e **chiaramente** la **complessità** e l'**aumento** poi del numero di persone, eccetera, ha portato all'**aumento** dell'attività, la presenza di più persone ha **ovviamente** non solo aumentato la **complessità**, ma anche generato alcune **criticità** in alcuni casi, se fai poco hai meno probabilità di fare].*

The gradual transition from a **consulting model** to an integrated, multidimensional, multi-proportional **model**, integrated with the various areas and departments of the hospital, and **clearly** the **complexity** and **increase** in the number of people has led to an **increase** in activity. The presence of more people has not only increased **complexity** but also generated some **critical issues** in certain cases.

*[il progressivo passaggio superamento del **modello consulenziale** ad un **modello** invece di intervento integrato, multidimensionale, multi proporzionale, integrato con i vari ambiti, reparti dell'ospedale, e **chiaramente** la*

complessità *e l'****aumento*** *del numero di persone ha portato all'****aumento*** *dell'attività, la presenza di più persone ha non solo aumentato la* ***complessità****, ma anche generato alcune* ***criticità*** *in alcuni casi].*

There have been many changes that may **concern** the number of beds, the organization of departments, the opening of new **types** of activities, changes in procedures, the introduction of a new type of care, the hiring of many young staff members and the retirement of many others [...] these are the first ones that come **to mind**, structural changes in the hospital.

[ci sono stati tantissimi cambiamenti che appunto possono ***riguardare*** *i posti letto, l'organizzazione dei reparti, l'apertura di nuove* ***tipo*** *di attività, la modifica di modalità di intervento, l'introduzione di una modalità di assistenza, il sopraggiungere dell'assunzione di molto personale giovane e molto personale che è andato in pensione [...] questi sono i primi che mi vengono* ***in mente****, cambiamenti strutturali nell'ospedale].*

Cluster 2: Organizational challenges. This cluster highlights difficulties in workforce management, including shortages, shifts and recruitment processes. Representative lemmas such as "group", "competition", "staff shortages", "shifts" and "company" indicate the strain on human resources, particularly in the context of economic constraints and operational limitations. The most representative ECUs of this cluster were:

The **organizational** system around us changed, and then the subject we deal with changed. [...] There were no **selection processes**, to make a comparison in terms of time. I took part in my first **selection process** in 2017 [...] and the next **selection process** was announced in 2019.

[è cambiato il sistema ***organizzativo*** *intorno, e poi è cambiato l'oggetto di cui noi ci occupiamo. [...] Non c'erano stati* ***concorsi****, per fare un paragone temporale. Il primo* ***concorso*** *l'ho fatto nel 2017 [...] e l'altro* ***concorso*** *è stato bandito nel 2019].*

[...] no investments have been made in hiring staff, so in recent years since my arrival, a ranking list has been used, but only for a short period of time, because then the ranking expired and fortunately the services were **covered**, but not to the extent necessary to **cover** turnover, so there is a great **shortage** of psychologists, but there is also a great **shortage** of neuropsychiatrists.

[...] non ci sono stati investimenti fatti in assunzione del personale,

*quindi, negli ultimi anni dal mio arrivo si è utilizzata una graduatoria, però per un breve periodo di tempo, perché poi la graduatoria è scaduta e quindi fortunatamente i servizi sono stati **coperti**, ma non per la quota necessaria a **coprire** il turnover quindi c'è una grande **carenza** di psicologi, ma c'è anche una grande **carenza** di neuropsichiatri].*

We called ourselves a bridge and filter **group**. A bridge between the hospital where I spent one day a week and the district where I worked. A filter because this **group** of colleagues filtered out the more complex **situations**.

*[Un po' un **gruppo** lo chiamavamo ponte e filtro. Ponte fra l'ospedale dove stavo un giorno a settimana e il territorio dove operavo a livello distrettuale. Filtro perché questo **gruppo** di colleghi filtrava un po' le **situazioni** più complesse].*

Cluster 3: Service networking. This cluster describes the transformation of professional roles within the health and academic systems, with an emphasis on networking and institutional relations. Terms such as "director", "network", "services", "history" and "evaluation" suggest an increasing complexity in the definition of roles, decision-making processes and inter-institutional collaborations. The most representative ECUs of this cluster were:

Exactly ten years ago, the simple clinical psychology unit was established in **Borgo Roma** and **Borgo Trento**, so it has been exactly ten years. Before that, they did not exist. Then, in 2014, there were two separate entities: the one in **Borgo Trento** was hospital-based, while the one in **Borgo Roma** was university-based, in terms of hierarchy, organization, and structure, so to speak.

*[esattamente dieci anni fa è nata l'unità semplice di psicologia clinica di **Borgo Roma** e anche di **Borgo Trento**, quindi, esattamente dieci anni. Prima non esistevano. Poi, nel 2014 erano due entità, appunto, separate, quella di **Borgo Trento** era ospedaliera, quella di **Borgo Roma** era universitaria, come apicalità e come organizzazione, come struttura, diciamo].*

Right now, I'm a delegate from the hospital in the city foundation, and this has an **important** impact on how things work. Some of my coworkers also have **connections** in the area. One of them has a good relationship with the city government, so they're more aware of certain things. So, even people who work in the service have **connections** in the area.

*[In questo momento sono membro delegato dall'ospedale dentro la Fondazione cittadina e questo ha un influsso **importante** sull'andamento del servizio, anche alcuni colleghi hanno **contatti** sul territorio. Un collega ha un buon rapporto con l'amministrazione comunale e quindi su alcune cose c'è più sensibilità. Quindi anche le persone che sono dentro un servizio hanno **contatti** sul territorio].*

Two aspects that I find significant are also the [...] extensive network of **contacts** with regional **networks**, such as the perinatal **network**, the hematology **network**, the oncology **network**, and the psi-nefro **network**, which are beneficial **contacts** in certain respects.

*[Due aspetti che mi sembrano significativi sono anche la [...] massiccia presenza di **contatti** con le **reti** regionali e ad esempio la **rete** per la perinatalità, la **rete** ematologica, la **rete** oncologica, la **rete** psi-nefro e quindi sono dei **contatti** per certi aspetti benefici].*

Cluster 4: Service consolidation. This cluster focuses on the professionalization of the service seen as the process of transformation from temporary/unstable situations to consolidated and recognized structures. Lemmas such as "stabilization", "psychologist", "psychology", "care" "functional", "department" and "change" reflect both staff and organizational stabilization. The most representative ECUs of this cluster were:

It is a job that is carried out with the **stabilization** of the two colleagues, with psycho-oncology activities that are exclusive and **dedicated** to the oncology department and carried out by the two senior **psychologists**. So the important **change** was their **stabilization** and therefore their presence in the **care** of cancer **patients** and related caregivers.

*[è un lavoro che viene svolto con la **stabilizzazione** dei due colleghi, con le attività di psiconcologia che sono esclusive e **dedicate** al reparto di oncologia e svolta dai due dirigenti **psicologi**. Quindi il **cambiamento** importante è stata la loro **stabilizzazione** e quindi la loro presenza nell'ambito della **cura** dei **pazienti** oncologici e dei caregiver collegati].*

So the hierarchical dependence of **psychological** managers has increased, as has the whole area of so-called **functional** dependence, i.e. within my operational unit. [...] But what is happening today is that, essentially, all **psychologists** belonging to all operational units report in some way, for reasons of strategy, updating, or training, to the clinical **psychology** operational unit.

*[Quindi la dipendenza gerarchica di personale di dirigenti **psicologi** è aumentata ed è aumentata anche tutta l'area della dipendenza cosiddetta **funzionale**, cioè dentro la mia unità operativa. [...] Ma quello che succede ad oggi è che, sostanzialmente, tutti gli **psicologi** che appartengono a tutte le unità operative fanno capo in qualche modo, per ragioni di strategia, per ragioni di aggiornamento, per ragioni di formazione, all'unità operativa di **psicologia** clinica].*

The **change** we are currently undergoing is that national and **regional** law stipulates that a primary **care psychology** service must be established and that this service must not be dependent on the DSMD, i.e. the mental health and addiction **department**, which is the hierarchical structure to which my operational unit belongs.

*[Il **cambiamento** che abbiamo adesso in corso è che la legge nazionale e **regionale** prevede che sia istituito il servizio di **psicologia** delle **cure** primarie e che questo servizio non dipenda dal Dsmd, quindi dal **dipartimento** di salute mentale delle dipendenze, che è la struttura gerarchica dove appartiene la mia unità operativa].*

Table 1 lists the 10 most characteristic lemmas for each cluster.

Table 1. *Characteristic lemmas of the extracted clusters*

Cluster 1 – Organizational complexity			**Cluster 2 – Organizational challenges**		
Lemmas (Italian)	*Chi-square*	*p*	*Lemmas (Italian)*	*Chi-square*	*p*
Clearly *(Chiaramente)*	22.20	< .001	Group *(Gruppo)*	23.90	< .001
Covid *(Covid)*	21.99	< .001	Talk *(Parlare)*	20.85	< .001
In mind *(In mente)*	21.99	< .001	Situation *(Situazione)*	20.85	< .001
Type *(Tipo)*	21.99	< .001	Competition *(Concorso)*	17.31	< .001
Greater *(Maggiore)*	18.35	< .001	Company *(Azienda)*	17.25	< .001
Complexity *(Complessità)*	17.59	< .001	Economic *(Economico)*	16.72	< .001
Model *(Modello)*	17.59	< .001	Shortage *(Carenza)*	12.21	< .001
University *(Università)*	17.59	< .001	Search *(Cercare)*	11.82	.001
Criticality *(Criticità)*	12.99	< .001	Shift *(Turno)*	11.82	.001
Increase *(Aumento)*	12.52	< .001	Bring *(Portare)*	9.98	.002

Cluster 3 – Service networking			Cluster 4 – Service consolidation		
Lemmas (Italian)	*Chi-square*	*p*	*Lemmas (Italian)*	*Chi-square*	*p*
Town *(Borgo)*	42.53	< .001	New *(Nuovo)*	11.69	.001
Important *(Importante)*	21.59	< .001	Stabilization *(Stabilizzazione)*	11.21	.001
Contacts *(Contatti)*	18.87	< .001	Care *(Cura)*	10.79	.001
Woman *(Donna)*	18.87	< .001	Functional *(Funzionale)*	9.96	.002
Experience *(Esperienza)*	18.87	< .001	Psychologist *(Psicologo)*	8.95	.003
Rome *(Roma)*	18.87	< .001	Psychology *(Psicologia)*	8.80	.003
Role *(Ruolo)*	18.87	< .001	Free *(Libero)*	7.46	.006
Variable *(Variabile)*	18.87	< .001	Regional *(Regionale)*	7.16	.007
Trento *(Trento)*	18.04	< .001	Department *(Dipartimento)*	7.02	.008
Story *(Storia)*	16.27	< .001	Change *(Cambiamento)*	6.90	.009

Note. Only the first 10 lemmas are shown.

The COR analysis identified two factors corresponding to semantic structures, which organize the extracted clusters. The most representative lemmas for each factor are reported in Table 2. The research team labeled the factors as follows through a consensus-based approach (Harris *et al.*, 2012; Schielke *et al.*, 2009):

Factor 1: Professional practice vs Networking. This factor contrasts a focus on clinical and professional activities (negative pole) with an emphasis on collaboration (positive pole). At the negative pole, lemmas such as "operational" (vtest = -3.05), "work" (-2.46), "change" (-2.45), and "patient" (-2.15) reflect a perspective centered on clinical practice. Conversely, the positive pole is characterized by terms like "town" (vtest = 6.50), "important" (4.54), "contacts" (4.33), "role" (4.33), which underscore the emphasis on institutional relationships and collaborative networks.

Factor 2: Challenges vs. Empowerment. The second factor contrasts a focus on difficulties and constraints (negative pole) with

proactive adaptation and professional agency (positive pole). At the negative pole, lemmas such as "see" (vtest = -4.12), "organizational" (-3.70), "COVID" (-3.68), "criticality" (-3.61) highlight the challenges faced by the service, including pandemic-related disruptions. At the positive pole, lemmas like "operative" (vtest = 2.91), "stabilization" (2.88), "new" (2.80), "functional" (2.72) underscore proactive responses to challenges and service consolidation.

Table 2. *Characteristic lemmas of the extracted factors*

Factor 1				**Factor 2**			
Professional practice		***Networking***		***Challenges***		***Empowerment***	
Pole (-)	*Vtest*	*Pole (+)*	*Vtest*	*Pole (-)*	*Vtest*	*Pole (+)*	*Vtest*
Operational *(Operativo)*	-3.05	Town *(Borgo)*	6.50	See *(Vedere)*	-4.12	Operative *(Operatorio)*	2.91
Work *(Lavoro)*	-2.46	Important *(Importante)*	4.54	Organizational *(Organizzativo)*	-3.70	Stabilization *(Stabilizzazione)*	2.88
Change *(Cambiamento)*	-2.45	Experience *(Esperienza)*	4.33	In mind *(In mente)*	-3.68	New *(Nuovo)*	2.80
Unity *(Unità)*	-2.37	Woman *(Donna)*	4.33	Covid *(Covid)*	-3.68	Functional *(Funzionale)*	2.72
Patient *(Paziente)*	-2.15	Contacts *(Contatti)*	4.33	Type *(Tipo)*	-3.68	Performance *(Prestazione)*	2.58
See *(Vedere)*	-2.03	Rome *(Roma)*	4.33	Criticality *(Criticità)*	-3.61	Regional *(Regionale)*	2.57
Become *(Diventare)*	-1.98	Role *(Ruolo)*	4.33	Clearly *(Chiaramente)*	-3.49	Room *(Stanza)*	2.45
		Variable *(Variabile)*	4.33	Concern *(Riguardare)*	-3.31	Care *(Cura)*	2.38
		Trento *(Trento)*	4.22	Model *(Modello)*	-3.29	Free *(Libero)*	2.35
		Story *(Storia)*	4.07	University *(Università)*	-3.29	Colleague *(Collega)*	2.23

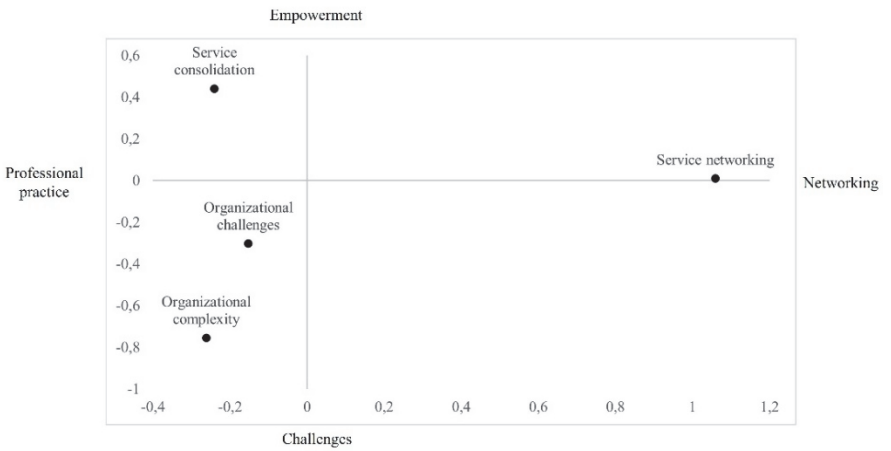
Note. Only the first 10 lemmas are shown.

The factorial space (Figure 1) provides a spatial representation of the four identified clusters based on the two extracted dimensions. Two clusters are positioned in the lower-left quadrant, indicating a strong association with the challenges faced by the services: *Structural complexity* (-0.26, -0.75) is the most extreme case on this axis, highlighting how the pandemic has exacerbated critical issues and organizational burdens. *Organizational challenges* (-0.15, -0.30) is similarly aligned with practical difficulties, though less extreme, reflecting the constraints faced by professionals in managing resources and workloads.

Service consolidation (-0.24, 0.44) is located in the upper-left quadrant, indicating a dual association with professional practice (Factor 1, negative pole) and empowerment (Factor 2, positive pole). This position indicates that the theme is shaped by the improvements adopted to address the challenges.

Service networking (1.06, 0.01) is the only cluster positioned on the right side of the factorial space, reflecting its association with the Networking pole of Factor 1. This placement underscores its distinct focus on collaboration rather than professional practice.

Figure 1. *Graphic representation of the themes along the two semantic structures*



Discussion

The present study aimed to examine the transformations in Hospital Psychology Services (HPS) over the past decade, with a particular focus on how professionals represent these changes.

Grounded in the Semiotic-Cultural Psychology Theory, the research highlights that Italian hospital psychology professionals represent the evolution of services according to four different themes concerning the complexity of the services, their challenges, their networks and consolidation.

The results of the study show that clusters, as interpreted, lend themselves to being understood as indicative of the dialectical intertwining between critical issues and evolutionary trajectories that have characterized the medium-term evolution of hospital psychology (Kidd & Styron, 2020). This dialectical intertwining can be mapped in terms of the two semantic structures identified by the analysis.

The first dimension extracted is interpreted in terms of a semantic structure which highlights the dialectic between two evolutionary dimensions understandable in terms of professional practice vs. networking. On the one hand, the process of internal consolidation of specialized professional practices; on the other, the enhancement of the hospital psychology functions as a device for strengthening the ability to establish collaborative networks.

The second semantic structure lends itself to being interpreted as the general dynamic that has driven the evolution, namely the changes that have challenged hospital psychology, and more generally the hospital institution, and the reinforcement to respond to them. This dialectic has to do, on the one hand, with institutional and functional consolidation in relation to the critical conditions that the psychological function has had to face (challenges); on the other hand, there is the reinforcement of the services (empowerment).

Moreover, the study identified four themes (Organizational complexity, Organizational challenges, Service networking, and Service consolidation), which can be viewed as the representational traces on the respondents' imaginary of the major outputs of the developmental trajectories outlined above.

The theme *Structural complexity* seems to refer to the transition of HPS from a purely consultative model to an integrated one. This

aspect is highlighted in the literature (De Berardinis & Dondi, 2020) and seems to reflect a need to adapt to increasingly demanding healthcare contexts, a factor that has been particularly evident during the COVID-19 pandemic. In this context, professionals' narratives about the evolution of services in terms of complexity indirectly support the arguments put forward by several scholars, who argue that emergencies act as catalysts for service change (Omboni *et al.*, 2022; Rutkowska, 2022).

The theme *Organizational challenges* seems to concern the critical issues that services have faced over time. These difficulties, such as staff shortages and limited resources compared to the high demand for psychological assistance, are highlighted in the literature, which shows that these issues are not limited to HPS but are widespread in healthcare systems (Bell *et al.*, 2020; Russell *et al.*, 2021). Furthermore, some studies have shown that these difficulties have prompted professionals to find innovative solutions to meet the needs of the population (Stringer, 2024), such as the use of telepsychology (Hirko *et al.*, 2020; Pierce *et al.*, 2021).

The theme *Service Networking* seems to reflect the evolution of services towards greater connection with the outside. Indeed, professionals' narratives have also focused on how, in recent years, services have progressively expanded their network of relationships with local entities and communities. This trend is particularly important given that the adoption of integrated care models that leverage collaborative networks has been recognized as crucial to ensuring population health (Alderwick *et al.*, 2021).

Finally, the theme *Service consolidation* seems to relate to the growing stabilization of the role of psychology within healthcare systems, particularly in response to contemporary challenges. According to professionals, this consolidation has affected both the internal organization of services and the achievement of greater disciplinary autonomy within hospitals. This dual process mirrors the evolution documented in the literature on hospital psychology, which has seen a gradual recognition of its distinctive role within the hospital setting (Kidd & Styron, 2020; Wahass, 2005).

Some limitations of the present study should be acknowledged. First, the research focused exclusively on Italian services, which may limit the generalizability of the findings to other cultural and

healthcare contexts. Differences in healthcare systems, funding models, and policy frameworks across countries could significantly influence how psychological services evolve and are perceived. Second, the quali-quantitative nature of the study, while rich in depth, does not allow for statistical generalizations or causal inferences. Future research could benefit from mixed-method approaches, combining qualitative analyses with quantitative measures to assess the prevalence and impact of specific changes. Third, the sample, though representative of Italian HPS, was relatively small (27 services), and the participation rate (51.9%) may introduce self-selection bias, as services facing greater challenges or those more innovative might have been more likely to respond. Finally, while the ACASM methodology offers a rigorous approach to textual analysis, the interpretation of clusters and factors inevitably involves a degree of researcher subjectivity, despite consensus procedures aimed at minimizing bias. These limitations suggest caution in extrapolating the findings but also highlight opportunities for further research to expand and validate these results in diverse settings and with complementary methodologies.

This study provides a first overview of how the representational world of hospital psychologists can serve as a marker of the transformations taking place in the sector. Future research could extend this analysis through longitudinal approaches in order to track these developments. Furthermore, comparative studies between different countries could identify similarities or differences between services belonging to different cultural contexts.

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The Evolving Landscape of BPD Treatments: What GET (Group Experience Therapy) can add up to standardized treatment for BPD

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Abstract

The clinical management of the borderline personality disorder (BPD), and of emotional dysregulation disorders in general, raises problems both during the diagnostic and the treatment processes. Despite these challenges, clinical experience and the data from the literature make evident that the remission of the symptoms and the recovery from such disorders is now possible, under the condition of being treated with continuity. Various effective therapeutic approaches are available, such as the Dialectical Behavioral Therapy (DBT), the Mentalization-based Therapy (MBT), the Transference Focused Therapy (TFP). Of late, although the current body of research remains limited, preliminary evidence suggests that the multilevel experiential approach, Group Experience Therapy (GET) has shown promise in managing emotional dysregulation, reducing suicidal and self-harming behaviors, and enhancing patients' quality of life. This paper serves as a brief introduction to the model's rationale.

Keywords: Borderline Personality Disorder, Borderline Personality, Emotional dysregulation, Group psychotherapy, Objectual relationships, Recovery.

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Introduction

Borderline personality disorder (BPD) is a debilitating mental disorder characterized by severe instability in affect, identity, interpersonal relationships, and emotional dysregulation.

The age onset of BPD varies but symptoms are usually manifested in early adulthood. In the adult general population, rates for BPD range between 0.7 and 2.7%, whereas the prevalence rates are higher in 6% primary care (6%), psychiatric outpatients (11-12%), and psychiatric inpatients (22%) (Leichsenring *et al.*, 2024).

The literature has shown a prevalence of BPD among women. Tomko and colleagues (2014) have noticed slightly higher rates of BPD for women compared to men (3% vs. 2.4%) in a US community sample. In the same direction, Zimmerman and Becker (2023) found considerably higher rates of BPD in women compared to men (72% vs. 28%) in a psychiatric outpatient setting. Beside the female prevalence, there are gender differences in comorbidity: women more frequently show mood, anxiety and eating disorders, and PTSD, while men with BPD exhibit more frequently substance abuse and antisocial personality disorder.

BPD is a severe condition deserving careful clinical attention. Indeed, it is estimated that more than 75% of people who suffer from BPD are likely to enact self-harming behaviors voluntarily (Oldham, 2006). Between 60% and 70% can be defined as proper suicide attempts, considering the specific intention to end their own life; this is evident by looking at the statistics, which show that 10-15% of patients directly die by suicide (Black *et al.*, 2004; Leichsenring *et al.*, 2011). Recent longitudinal data show that a total of 5.9% of borderline patients vs. 1.4% of control subjects died by suicide. Additionally, 14.0% of borderline patients and 5.5% of control subjects died by non-suicide causes (Temes *et al.*, 2019). It is also added how within borderline patients, number of prior hospitalizations significantly predicted completed suicide (Temes *et al.*, 2019).

Despite this worrying data, detecting people at high risk of attempting suicide and enhancing suicide prevention strategies in clinical practice remains a challenge so far (Franklin *et al.*, 2017). The attendance of a psychiatric treatment is a relative protective factor: several patients with BPD are prone to suicide attempts even while

undergoing a psychotherapy program, independently of the theoretical approach, thus making even more complex the management of the disorder (Brown and Chapman, 2007).

Notwithstanding such remarks, BPD has a better prognosis than it was thought in the past. Clinical experience and the data from the literature make evident that the remission of the symptoms and the recovery from borderline personality disorder is now possible, under the condition of being treated with continuity (Setkowski *et al.*, 2023; Crotty *et al.*, 2023; Storebø *et al.*, 2020; Ellison *et al.*, 2020; Oud *et al.*, 2018; Juanmartí *et al.*, 2017).

In a review by Ng and colleagues (2016), the authors found that the levels of symptom's remission and recovery differ due to individual differences and the studies' methodology. According to the authors, to recover means achieving a condition characterized by the ability to manage symptoms, and to comprehend their function within one's life, by also individualizing personal goals and applying specific strategies towards them. The achievement of a better quality of life always requires maintaining long-term adaptive models (Nesnidal *et al.*, 2020).

In line with the Practice Guidelines for the Treatment of Patients with BPD (APA, 2024; Substance Abuse and Mental Health Services Administration, 2012), recovery should be understood not only in overcoming symptoms and stopping critical behaviors, but also in:

1. better capacity of reaction to adverse events;
2. developing a positive idea of one's own social and personal identity;
3. feeling like you belong to a social network;
4. looking at the future with trust;
5. finding meanings and goals in one's own life;
6. beginning a path of self-awareness and restructuring of their identity.

The definition of the term "Borderline"

In 1938, Stern described for the first time the concept of "Borderline" as a mental issue characterized by deep psychological suffering, extreme hyper-sensibility, feelings of inferiority, anxiety, mechanisms of projective identification, reality-testing disturbances. (Stern,1938)

From the beginning, Stern considered these patients particularly challenging to comprehend and treat.

In 1975, Kernberg stated these patients must be considered to occupy a borderline area between neurosis and psychosis. The characteristics of Borderline Personality Organization (BPO) were: identity diffusion (no integrated concept of self and significant others), use of primitive defenses (such as splitting, denial, projective identification etc.) and variable reality testing (Kernberg,1975; Caligor 2007).

In 1980, in the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III), a new section titled "Axis II" was elaborated, dedicated to personality disorders, including the Borderline disorder. In the latest edition of DSM-5TR (2022), Borderline Personality Disorder (BPD) is described as a pervasive pattern of instability in interpersonal relationships, self-image, and emotion, as well as marked impulsivity beginning by early adulthood and present in a variety of contexts. It can be diagnosed if at least 5 of the symptoms reported in the diagnostic manual are present in the patient.

Furthermore, due to many problems associated with the categorical models (Monaghan *et al.*, 2023) – as the high levels of comorbidity and low level of reliability – in the DSM-5TR it is proposed an alternative dimensional model. However, some essential features for the diagnosis of personality disorders are maintained in both models (for both DSM-5 and 5TR, for example, having an impaired functioning must be a requirement and the diagnostic criteria stay the same).

It is important to highlight how there is still a controversy on the conceptualization of BPD as a specific disorder or as a level of functioning identifying a general impairment of personality (Tyrer *et al.*, 2019; Bach *et al.*, 2020; Mulder *et al.*, 2020). Moreover, in a recent review, Leichsenring and colleagues (2024) highlighted that – even though the construct of BPD is more coherent and trustable than we may believe – difficulties still persist in the diagnostic process due to very high level of symptomatology variability, frequent comorbidities with other psychopathological diagnosis, and differentiation from other diagnoses. In fact, frequently, patients with BPD are misdiagnosed, disliked, and overmedicated. Such practices persist despite considerable knowledge of how patients can be effectively treated (Gunderson, 2018).

We would like to clarify that in our view, starting from Kernberg's

theory for BPO (that will be introduced in the next section), we prefer to use the term "borderline functioning" since we consider it to be a modality to function in the world for the personality: the term describes how the person thinks, feels, acts and behaves. The definition of borderline personality disorder (BPD) will be used, in this article, when we quote research that use this term.

The borderline personality functioning: the emotional dysregulation

In this section we will try to clarify our specific theoretical model on BPD, which integrates different perspectives derived from psychodynamic theories of attachment and object relations, neurobiology, and phenomenological observation of patients' behavior.

The possible causes of BPD

Several developmental models suggest that BPD features are determined by a combination of biological and environmental mechanisms, the latter of which includes social and attachment-related disturbances (Linehan, 1993; Zanarini, 1997; Hughes, 2012)

According to many studies, at the origin of the emotional dysregulation and of the BPD, there is an interaction of many factors including:

1. biological vulnerability of the limbic cortex (Perez-Rodriguez *et al.*, 2018; Allen, Fonagy, 2008; Lis *et al.*, 2007; Linehan, 1993).
2. invalidating developmental context, related to intolerance toward the expression of private emotional experiences (Crowell *et al.*, 2009; Allen, Fonagy, Bateman, 2008; Linehan, 1993).
3. adverse childhood experience (Bozzatello *et al.*, 2021; Porter *et al.*, 2020; Kuo *et al.*, 2015; Fonagy 1996).

About point 1, in terms of neural systems, many studies suggest a frontal-limbic imbalance in BPD, in which emotion dysregulation is mediated by the hyperactivity of limbic structures (i.e., amygdala, hippocampus, and anterior cingulate cortex) and the abnormal functioning of prefrontal structures. The hyperactivity of the amygdala and the

hippocampal areas during emotional processing in BPD patients seems to be accompanied by impairments in habituation of the amygdala to repeated negative stimuli. The consequences of these impairments are higher levels of anxiety traits, aggressivity, and affective lability (Hazlett *et al.* 2012; Koeningsberg *et al.*, 2014; Bilek *et al.*, 2019). It is noted that BPD patients show structural cerebral alterations: reduction of the sizes of amygdala, hippocampus, insula, anterior cingulate cortex, orbitofrontal cortex, and dorsal prefrontal cortex; enlargement of the precuneus and posterior cingulate cortex (Ruocco *et al.*, 2012, Schulze *et al.*, 2016; Yang *et al.*, 2016; Perez- Rodriguez *et al.*, 2018).

Coming to the environmental influences, research (Fatimah *et al.*, 2020; Stepp *et al.*, 2016; Bailey *et al.*, 2015) revealed that the borderline personality can be associated with a family environment characterized by high emotional expressivity, conflicts, difficulty in dialogue, and limited reciprocal comprehension. Accordingly, borderline people often describe their family environment as unable to respond to their needs and comprehend their emotional states.

An environment that views emotions and their expressions as incomprehensible or not justifiable, if compared to the intensity of the events triggering the emotional activation, can be called invalidating. This kind of environment can be found not only in the family, but also at school, at work or, in general, in any kind of social relationship.

We can assume that this sort of environment is a combination of emotional, psychological, and relational experiences- past or present- that does not allow the proper development of object permanence and secure attachment. Consequently, borderline individuals have a higher probability of having a disorganized Self, and inconsistent self-esteem. Hence, this leads to a great difficulty in trusting others in relationships, becoming a source of anxiety.

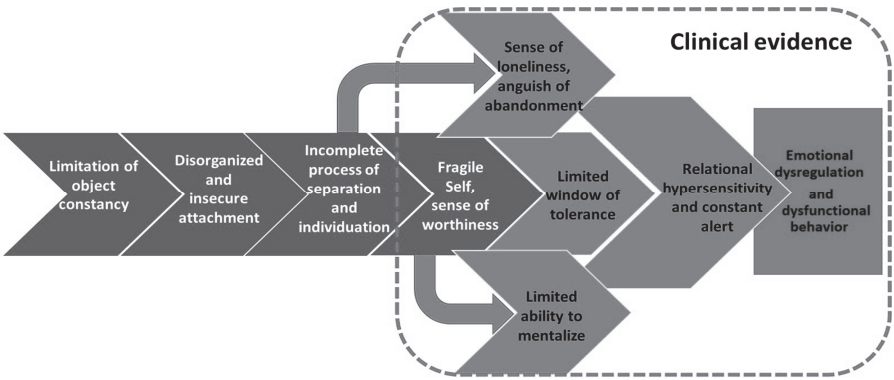
Another consequence of an invalidating surrounding, combined with emotional vulnerability, is the difficulty in recognizing and managing emotions, which are often felt with high intensity as we will explain later.

In summary – as shown in Figure n. 1 – the invalidating environment, the limitations of object permanence and insecure attachment are combined with an incomplete process of separation and individuation. As a matter of fact, borderline individuals are not able to handle

life events with the adequate adaptability and personological maturity. The consequences are fear of abandonment, instability in relationships and a feeling of constant alertness of the borderline person within relationships: as the beloved one is also the one who could abandon, the person oscillates between devaluation and idealization.

All these elements make certain events to become triggers that can cause emotional dysregulation, critical behaviors and relational difficulties.

Figure 1. *An hypothesis of the etiopathogenesis of emotional dysregulation*



The emotional dysregulation

The core of borderline functioning is emotional dysregulation. The concept of emotional dysregulation refers to the difficulty to recognize, regulate and accept your own emotions in an effective way. The borderline patient experiences a deep psychic sufferance caused by the active vulnerability: patients perceive themselves as "out of control" and consequently unable to find functional strategies of emotional regulations, leading them to impulsive thoughts and behaviors.

The moment of emotional dysregulation is called a "crisis". Emotionally vulnerable individuals have difficulties in the regulation of their own emotions, and their behavior is absorbed in dealing with their intense emotions.

Emotional vulnerability (Linehan ,1993) regards three facets such as:

- High sensitivity: individuals react immediately to stimuli that usually leaves others indifferently.
- High reactivity: individuals have intense reactions that sometimes can be extreme, to the point of hindering awareness of what is happening.
- Slow deceleration of emotions back to baseline: individuals might experience emotions that last for a long time, whose return to the base line takes more time than usual.

Emotional vulnerability could be also linked with the wideness of the person's window of tolerance (Siegel, 2013), a concept illustrating the capacity to fluctuate while remaining within a range of acceptable emotional arousal. Borderline patients' window of tolerance is limited, resulting in hyperarousal or hypoarousal in response to external triggers.

In fact, every crisis is unleashed by a trigger: an event that causes the fear of abandonment, meaning the fear of losing the beloved one or the attention of someone we care about.

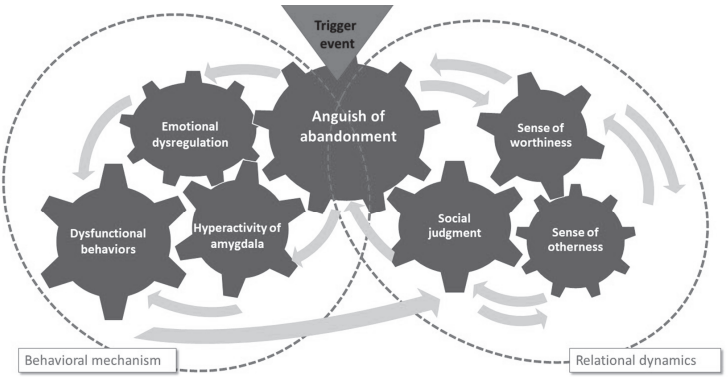
The trigger could be:

- External: an abandonment or rejection that actually happened,
- External + internal: an event that is felt and interpreted as an abandonment or rejection, even if maybe it is not,
- Internal: a thought or negative rumination that the person has in his/her own mind.

As shown in image n. 2, the trigger activates the fear of abandonment which, in turn, activates different levels: the neurobiological level and the emotional and/or relational level.

Hence, the trigger of the fear of abandonment activates rapidly the amygdala, which can lead to a precipitous reaction of fight or flight. The person feels overwhelmed by the intense emotions, and is unable to properly cope with the situation, that is, to behave in a way capable of lowering the levels of emotional activation. These behaviors lead to emotional and relational consequences, for example, feelings of unworthiness, of being different, and fear of social judgment. So, these feelings are the cause of fear and the effects of the crisis itself.

Figure 2. *Our conceptualization of the mechanism of emotional dysregulation*



Impulsivity and "dysfunctional behaviors"

Impulsivity is another borderline functioning aspect linked with emotional dysregulation: as already illustrated, the tendency to react without control is a response to emotional intolerability. Impulsive behaviors are often defined as dysfunctional, but from the individual subjective perspective they serve to reduce the emotional dysregulation and regulate the person's reaction to the emotion.

Selby and Joiner (2009) proposed the "emotional cascade" model in which the emotional dysregulation, the impulsivity and the dysregulated behaviors are explained. They explain vicious cycles of intense rumination and negative affect that may induce aversive emotional states. Rumination leads to judgment, in fact individuals with borderline functioning have pessimistic attitudes about their relational failures that confirms their self-image as inadequate and unworthy. Indeed, the dysregulated behaviors are functional to stop this cycle and regulate emotional activation.

According to the emotional cascade model, borderline individuals are frightened of emotional experiences (positive and negative) because they are worried about losing control and the possible catastrophic consequences. This fearful reaction gives rise to two processes: on the one hand, the non-acceptance of feelings and no emotion recognition, and, on the other hand, the tendency to avoid or stop

the subjective experience of emotions. In fact, avoidance is one of the strategies that allows the individual to not experience the situation that might potentially involve emotional pain or anguish. This leads to an incomplete experience of emotions and reduces the possibility of recognizing and regulating them.

As known, other strategies for regulating the intensity of emotions are the impulsive behaviors that we mentioned above (i.e., verbal and physical aggression, self-harming such as cutting or burning themselves, reckless driving, etc.). It should be noted that Self-harm can be divided into nonsuicidal self-injury (NSSI) and suicidal behavior (SB). They can be tangible symptoms for underlying problems of emotion regulation, impulse control, and interpersonal relations.

The therapeutic relationship with borderline patients and the treatment

Psychotherapy is the treatment of choice for BPD and several psychotherapy approaches were specifically developed for the BPD. In the relationship with BPD patients, clinicians are stimulated by multiple challenges (Bellino *et al.*, 2016) dealing with the core of the disorder: the affective and relational instability, behavioral impulsivity, and the fragile definition of identity. The elements that make therapy a complex endeavor regard all the dimensions of the intervention:

- the patient (suicidal risks, aggressive conducts, the complexity of the disorder, disorganized attachment styles);
- the therapist (required competencies and skills, intense countertransference, burnout risk);
- and the psychotherapy setting (patients' selection, building the therapeutic trust, the requirement of a structured contract, duration and conclusion of the therapy).

For these reasons, the ratio of premature dropout is often very high (Wnuk *et al.*, 2013; Arntz *et al.*, 2023; Iliakis *et al.*, 2021).

In fact, the difficulties and risks (considering for example the ones mentioned above) in relationships addressed by those suffering from BPD manifest also in the therapeutic relationship and represent a constant challenge, often difficult to handle. For example, the therapist could be extremely invested in the therapeutic relationship or dealing with extreme anguish or on the contrary trying to establish distance and rigid boundaries in the relationships, which raise the problems of conflict.

The literature suggests that the treatment of patients with BPD should begin with disclosure of the diagnosis and education about the expected course, genetics, and treatment of the disorder (Leichsenring, 2024). The consequence should be a reduction of the possible negative impact of the diagnostic label and could create a trusting relationship with the clinician.

The literature highlights how we have been taking big steps in the construction of more efficient treatments for BPD and that several approaches have been shown to be efficient, such as Dialectical Behavioral Therapy (DBT) (Hernandez-Bustamante *et al.*, 2024), Mentalization-based Therapy (MBT) (Vogt *et al.*, 2019), and Transference Focused Therapy (TFP) (Seyedi Asl *et al.*, 2024).

Therefore, considering what just discussed, we suggest not to work alone and independently. According to the literature (Hernandez-Bustamante *et al.*, 2024; Vogt *et al.*,2019) and based on our experience, the équipe is an essential and necessary resource to have in handling the complexity of the patient. As we will describe later, teamwork is considered an essential element for structuring a valid intervention, especially for GET, in that mutual comparison among professionals is an integral part of the method.

After having seen the main characteristics of BPD and the diagnostic-clinical challenges that characterize this condition, we now present the most influential treatment models.

Dialectical Behavioral Therapy (DBT)

DBT is a cognitive behavior therapy developed specifically for BPD by Marsha Linehan. According to this theoretical framework, emotional dysregulation is the upshot of the interaction between biological and environmental vulnerabilities. It is one of the primary targets of the treatment, since emotional dysregulation is understood as the source of all the other BPD's pathological manifestations.

The treatment focused on training and developing different skills in patients, including emotion regulation, mindfulness, stress tolerance, and interpersonal efficacy (Linehan, 1993; 2015).

DBT evolved from a combined motivational and capability deficit model of BPD. The idea was twofold: (1) borderline individuals lack

important interpersonal, self-regulation (including emotional regulation), and distress tolerance skills, and (2) personal and environmental factors inhibit the use of behavioral skills that the individual does have and often reinforce inappropriate borderline behaviors (Linehan, 1993).

The treatment consists of three different modes: psychosocial groups (for skills training), individual psychotherapy (addressing motivational issues and skill strengthening), and telephone contact with the individual therapist (addressing generalization).

It is characterized by a philosophy of dialectics, a biosocial theoretical perspective, a hierarchy of treatment targets specific to the mode, and a set of treatment strategy groups. Treatment targets are hierarchically arranged as follows:

1. Reducing high-risk suicidal behaviors (parasuicide and high-risk suicide ideation and plans).
2. Reducing therapy-interfering behaviors-all responses or behaviors of both the patient and the therapist that make therapy progress or continuation difficult (i.e., missing or coming late to sessions, phoning at unreasonable hours, refusing to collaborate or work in sessions, remaining interpersonally aloof or too clinging, invalidating the other, and not returning phone calls).
3. Reducing behavioral patterns serious enough to substantially interfere with any chance of a reasonable quality of life (serious substance abuse would qualify here).
4. Behavioral skill acquisition (skills in emotion regulation, interpersonal effectiveness, distress tolerance, and self- management, as well as a number of "core" [mindfulness] abilities to observe, describe, participate spontaneously, be nonjudgmental, focus awareness, and focus on effectiveness).
5. Reducing posttraumatic stress responses related to previous traumatic events.
6. Increasing self-respect.
7. Meeting other goals of the patient.

DBT efficacy has been proved as significant by many researchers. Here, we mentioned a recent review study conducted by Hernandez-Bustamante and colleagues that in 2024 have highlighted how both short-term DBT and standard DBT improved suicidality in BPD patients with small or moderate effect sizes, lasting up to 24 months after

the treatment period. Furthermore, the studies reviewed revealed that DBT has an efficacy on general psychopathology and depressive symptoms in patients with BPD.

Mentalization-based Therapy (MBT)

Let's now address Mentalization Based Treatment (MBT), a kind of therapy that promotes the development of mentalization. It has been tested in research trials and found to be an effective treatment for BPD (Vogt, 2019). Mentalization is a mental process that leads to perceiving and interpreting one's own and other people's behaviors as the result of internal and intentional mental states, that is, as the result of desires, beliefs, expectations, needs, goals, and feelings.

Having a good mentalization ability allows one to understand the affective manifestations of others, regulate emotions, control impulses, and self-monitor (Fonagy *et al.*, 1996). It is therefore a dimension of great interest for understanding the borderline personality organization, which is theorized to be characterized by a fragile mentalizing capacity. According to MBT, poor mentalizing skills are theorized to be the sources of emotional dysregulation.

MBT therapy can be done either with individual sessions or in groups. One of the first goals in MBT is to regulate emotional expression, because dysregulation, and the related impulsivity, negatively impact the internal representations. Another goal of MBT intervention is reinstating mentalizing when it is lost or to help to maintain it in any circumstance.

Primarily, the treatment uses some generic psychotherapy techniques such as empathy, support, and clarification, and then moves on to other interventions which place emphasis on the attachment relationship within controlled conditions, which includes a focus on the patient-therapist relationship through "mentalizing the transference".

The therapist's mentalizing therapeutic perspective is characterized by humility (a sense of "not knowing"), patience (in taking time for understanding others), a legitimizing stance towards others' perspectives, and proactivity in fostering descriptions ("what questions") rather than explanations ("why questions").

The attention of the therapeutic work is oriented in the present and

how this could influence the events of the past, not on the past itself. The therapist's duty is to direct the attention to the present and explore how the emotions from the past are activated in present situations. By recognizing the activated emotions, the therapist helps the patient to distinguish facts from their own subjective interpretations and the function of the behavioral answer.

Mentalization-based therapy was found to significantly reduce self-mutilating behaviors reporting a measure of parasuicidal behaviors, including two follow-ups (Bales *et al.*, 2012; Bateman & Fonagy, 1999; Kvarstein *et al.*, 2015; Rossouw & Fonagy, 2012).

The systematic review by Vogt (2019) indicates that MBT can achieve significant reductions in BPD symptom severity, severity of comorbid disorders, and use of psychotropic medication. It can also improve general psychiatric well-being, interpersonal functioning, and social adjustment. Borderline-specific features were also found to decrease over the course of treatment, including substantial reductions in parasuicidal behavior.

Transference Focused Psychotherapy (TFP)

Based on a sophisticated psychodynamic theoretical framework, Transference Focused psychotherapy (TFP) is treatment developed by Otto F. Kernberg and colleagues to treat severe personality disorders. The concept of *transference* refers to the feelings, attitudes, desires or fantasies expressed by the patient towards the therapist that appear to be based on the patient's past experiences about significant relationships, like the one with the caregivers. In fact, TFP is based on the centrality of the exploration of the patient's experience of self and others, through the observation of the patient's experience of the therapy and the therapist. The treatment also focuses on the patient's difficulties in work and relationships outside the treatment. Hence, the therapist's attention is focused on transference because it is believed that the observation of the patient's moment-to-moment experience of the therapist provides the most direct access to understanding the patient's internal world.

In summary, the core of TFP is helping patients to understand the shifts in borderline experience of themselves and others, as the split

sense of identity shows in the treatment relationship itself. As is clear, the main reference here is the theory of objectual relationships. According to TFP, emotional dysregulation is rooted in split conflictual objectual relationships, which shape disturbed relationships in real life. In fact, the patient has difficulties in tolerating and integrating disparate images of the self and others, so the therapist helps in containing the emotions and observe the enacted representations; moreover, the therapist understands the reasons, the wishes, fears and anxieties that support the continued separation of these fragmented senses of self and other.

The therapist also helps the patient to observe shifts in the dominant self-experience, using therapeutic techniques that include 1) clarification of internal states, 2) confrontation of observed contradictions, and 3) interpretation that helps explain the divisions and links between different states.

The work of TFP is structured by an initial phase of defining a limit-setting, with respect to the patient's destructive behaviors, and a longer phase of exploration of the patient's mind and sense of identity.

Accordingly, after confirming the diagnosis, the therapist and patient work to identify factors in the patient's life that might interfere with the consistency and conduct of the treatment (such factors could be drug abuse or addiction, chronic misuse of medication, a severe eating disorder, and self-injury and suicidality).

TFP has demonstrated efficacy in treatment of BPD's symptoms across various randomized clinical trials (Seyedi *et al.*, 2024).

Group Experience Therapy (GET)

Let's now address Group Experience Therapy (GET), a treatment that integrates several core elements of the models outlined above. The handbook describing GET's features has been recently published (Visintini, 2024), and with it one can argue that this treatment definitely strives for being included in the list of specific treatments for emotional dysregulation disorders. GET is a psychotherapeutic method whose development began in 2009, when a group of clinicians from the Day Hospital for the diagnosis and treatment of personality disorders (IRCCS Ospedale San Raffaele-Turro, Milan, Italy) began to formulate a methodology of intervention focused on the main critical

problematics of emotional dysregulation disorders. GET stemmed from the awareness that it is impossible to work within the traditional boundaries of only one therapeutic tradition: rather, it is evident the necessity to go beyond the classical approaches to properly address the peculiar features characterizing such complex disorder. In other words, the main goal grounding the elaboration of GET was to implement specific techniques focused on the different psychopathological manifestations of the disorder, drawing from and integrating cognitive, phenomenological, psychodynamic approaches.

The phenomenological approach inspires all the phases of GET treatment and the approach of therapists: the focus is on the lived experience and subjectivity of each individual, immersing in the patient's experience, seeking to understand the meaning they have for experiences, feelings, emotions and behaviors. The psychodynamic theories, on the other hand, inspire our view of DBP as an object relations disorder and its link with the development of object consistency (as Kernberg explains and as outlined in a previous section); psychodynamic approach is also the basis for the techniques used in the second phase of treatment.

At the same time, we keep in mind that the result of personality disorder is emotional dysregulation (as Linehan explains), which has a neurobiological basis and is also conditioned by an unsupportive/invalidating environment. The emotional dysregulation and the related clinical aspects, in the early stages of therapy, can only be addressed by cognitive experiential techniques.

So, with a view to the evolution of the person within the treatment, GET is structured in a way that starts from an approach based on cognitive techniques, to an approach based on psychodynamic ones.

The acronym of GET is explained as follows:

- GROUPS= The therapy is based on different group activities, which are the core and the heart of the treatment.
- EXPERIENCE = The experiential dimension emphasizes the importance of promoting and using the knowledge through the experience in the present, with the goal of evolving.
  In fact, experience is the base of thought, emotions, and actions, and it is the medium for developing new modalities to cope with life challenges.

So, in group, everyone elaborates in first person, together with their peers, new and more functional modalities to deal with and face up to emotions, relationships, and events of their own life.

- THERAPY = Thanks to the support of the équipe of psychotherapists and psychologists, the different group experiences acquire their therapeutic and transformative function. The patients who end the therapeutic path are no longer in the criteria of the diagnosis and there is an evolution of the self, recovering a better quality of life.

  Considering what just mentioned above, our treatment is based on a specific vision of the borderline organization of personality and the focus of its sufferings:
  - the crisis generated from the process of emotional
  - dysregulation;
  - the social avoidance;
  - the difficult or missing connection with one's own emotional;
  - world as well as one's own body perception;
  - the difficulties and conflicts of the object relationships.

  Each of these aspects is targeted by the different types of experiential groups characterizing the treatment, that we will describe later.

Focus on the role of the group

GET's principal therapeutic tool is the group. The theoretical framework we refer to is psychodynamic and starts from Lewin (1951) and the "field theory" and arrives at the "matrix concept" (Foulkes, 1964).

Following the Lewin (1951) definitions of a state of interdependence of fate and of task, we can say that the patients in the group recognize each other, having the same destiny, and in the course of treatment they also take on the same task, that is, to participate in the group work, where each group activity is focused on a specific task (crisis, planning, etc.).

GET's group main feature is homogeneity (with regards to the individuals' disorder and, as far as possible, their ages). Indeed, since groups are created in a way where members have similar

characteristics, the transformative power of therapy is amplified due to patients sharing their experiences with peers with whom they share significant aspects of their lives. In group, everyone elaborates in first person, together with their peers, new and more functional modalities to deal with and face up to emotions, relationships, and events of their own life.

In fact, the key role of the change process in patients is played by the interplay between learning new knowledge and lived experiences in interaction with peers in their group, and not by skills taught by the therapist.

For example, participation in Crisis and Planning groups allows one to develop a shared awareness of triggering events, interpretations and functions of risk behaviors, resulting in a sense of commonality of one's core suffering. In addition, groups allow for the sharing of a group culture and the experiential construction of strategies to prevent crises.

In this scenario the group builds a new matrix of reference. Being immersed in this new network and matrix, different from the one that contributed to the disorder, can become a transformative and therapeutic experience. In fact, experience is the base of thought, emotions, and actions, and it is the medium for developing new modalities to cope with life challenges.

In a more specific and clinical point of view, group therapy allows for different therapeutic factors:

1. installing and maintaining hope: comforting and comparing with other group members allows to witness the individual's change, observing, for example, people who have been in treatment the longest;
2. sharing information: what is said by a peer becomes an important resource because it implies reciprocal care and interest; for example, the psycho-educational notions, which may initially be provided by the facilitator, are almost immediately internalized and conveyed by the group itself;
3. experiencing the therapeutic factor of altruism: the patient does not feel only a burden to others but experiences a versatility of role that allows both him/her to receive and to give help;
4. learning socialization skills: for example, patients confronting each other by experientially learning how to manage possible conflicts or divergences of thought;

5. experiencing the therapeutic factor of imitative behavior: for example, through analysis of a crisis in which impulsive behavior was managed, a person may realize how certain strategies – found together during the group session – work for a groupmate and is more likely to implement them as well.

The teamwork

GET treatment is carried out by a team of professionals, under the responsibility of the équipe's coordinator.

Each group is held by a practitioner (i.e., psychologist, psychotherapist, or psychiatric rehabilitation technician) taking the role of "facilitator", i.e., he/she facilitates peers' interactions towards the group's goals and encourages their participation.

In addition to the group activities other professionals and roles are involved in the therapy process: the tutor (a psychotherapist) who conducts weekly individual sessions and is responsible for that patient's group work and follows him/her throughout the whole treatment; a psychiatrist or neuropsychiatrist (specialized in the treatment of this type of patients), who might be involved if medication is needed.

The team is not only a place of sharing topics about patients and therapy, but also a safe space to share the emotional burden that patients generate on the operators, a place of psychological processing and sharing for the operators themselves; this place is essential for the overwhelming and emotional engagement of the BPO patients and to reduce burnout risks. In fact, it is known that the patient with borderline personality organization brings emotional content and carries out behaviors that can generate fear, anguish, insecurity in the operators, and doubts about their work. Furthermore, these people often tend to establish relational dynamics – i.e., fusional or conflictual relationships, intense countertransference – that are difficult for the single operator to manage. It is therefore important that each operator shares these potential problems with the team.

All operators meet periodically to discuss cases, check their evolution and the progress of the treatment, and decide together the best way to address and resolve any potential problems; furthermore, teamwork allows the tutors to avoid being the only point of reference for the

patient and feeling excessively responsible for their patients' therapeutic progress.

Furthermore, ongoing training of GET practitioners, through supervision, enables them to possess skills necessary to manage the complex relationship with the borderline patient.

In summary, although many difficulties obviously persist in patient relations and treatment management, the GET's teamwork makes it possible to overcome them.

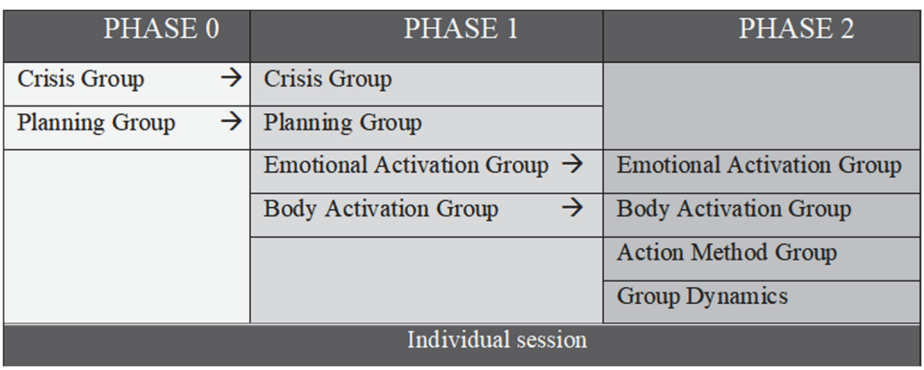
The structure of the GET treatment

The start of possible treatment is preceded by a psycho-diagnostic assessment phase, followed by the équipe discussion for intake, aimed at identifying the therapeutic intervention best suited to the needs and personological characteristics of each individual patient.

Overall, GET is a multilevel treatment whose activities are administered in a synchronic way: patients participate in a program where several activities – group and individual sessions – are planned each week.

As shown in image n. 3, the method is based on three consequential phases (consistent to the patient's evolution) and has an estimated duration of 2 years. Each phase envisages different kinds of groups: two group activities in phase 0 and four group activities in phase 1 and 2.

Figure 3. The GET method structure.



PHASE 0 – duration 3-6 months approximately

This is the initial phase where the patient encounters the idea of the group as a therapeutic instrument, it has a cognitive-phenomenological and psychoeducational approach.

During this phase, patients start to participate in activities, comprehend how to work in a group, and share their own symptoms with the group peers.

Phase 0 includes 2 groups activities:

• **Crisis Group**: starting to analyze and take into consideration the cognitive and emotional flows that give rise to crisis/emotional dysregulations and impulsivity. It is aimed at reducing the manifestations of impulsive behaviors.

• **Planning Group:** it's about coping with the potentially present and future dysregulating events. Analyzing, comprehending and limiting the avoidant behaviors are the goals of this group that focuses on the development of planning, and programming skills regarding daily activities and interpersonal interactions.

The patient might pass to Phase 1 when is assessed to be able to use the group as a therapeutic instrument, by being actively engaged in the treatment, and when he/she starts to show signs of change, by realizing that the mental state of oneself and others can differ, and it is possible to collaborate and manage social situations in groups.

PHASE 1 – duration 9-12 months approximately

The cognitive-phenomenological approach and the psychoeducational aspect, present primarily in Phase 0, are reduced progressively.

Phase 1 has two goals:

1. Proceeding the analysis, comprehension, and regulation of the emotional appraisal thanks to **Crisis** and **Planning Groups**.
2. Starting the process of emotional alphabetization and development of mentalization skills through the **Emotional Activation Group** and the **Body Activation Group**.
   - **Emotional Activation Group:** the aim is recognizing in

themselves and in others the expression of emotions. This can be attained through watching movies and focusing the attention on different aspects, such as facial expressions, behaviors, and language.

Through discussion among group members, it will be possible to outline a shared emotional language and vocabulary that allows different emotions to be distinguished and identified. As with other group activities, these are not "ex cathedra" lectures, but circular exchanges in which the facilitator encourages the construction of knowledge within the group context. Thus, there is no transmission of knowledge from an expert to patients, but rather the culture of the group begins to build a kind of emotional alphabet.

- **Body Activation Group:** during this group, the patients realize the centrality of their body in the comprehension of the emotions and in their regulation, mindfulness techniques are used.

In this Phase, the tutor starts a weekly session with the patients, and will support them during Phase 2, until the end of the treatment.

PHASE 2 – duration 9-12 months approximately

The patient is ready to pass in phase 2 when he/she acquires the capacity to regulate intense emotions and impulsivity, starts to acquire the ability to mentalize, and there is a reduction of self-harming behaviors. At this point of the treatment, the patient is also capable of not using invalidating judgment and rumination as the only obsessive modalities to think about themselves and the world around them, that usually made them feel invalidated, in pain, and inefficient. The consequences of the changes just described are positive: the emotional sufferance remains present but is less intense, constant and devastating; the presence of the first signs of a "psychological mind", defined by Appelbaum as «the ability of a person to see the relations between thoughts, emotions and actions, with the goal of comprehending the meanings and causes of their own experiences and behaviors» (1973, p. 36), and by Farber as «a disposition to reflect on the meaning and motivation of behaviors, thoughts and emotions of themselves and

others» (1985, p. 170). If a person starts therapy feeling like they have no control over their emotions or their mind, Phase 1 is where they begin to "keep the mind in mind".

Phase 2 continues the process of change, focusing more on relationships and is based on a psychodynamic and expressive approach. It is designed for improving evolutionary processes that started developing in earlier phases, such as: mentalization, improving relationship skills, and building a more mature and integrated sense of self.

This phase focuses on two main areas:

1. **Dynamics of the emotions**: with the tools learned in Phase 1, the person goes deeper into understanding and analyzing their emotions, especially through the **Emotional and Body Activation groups** according to the increased ability of the participants to reach a greater knowledge, awareness of their emotions, sensations and feelings.
2. **Relational dynamics**: through the **Group Dynamics** and **Action Methods group**, the person starts developing a different way of dealing with relationship issues, trying out new and more functional ways to interact with others.

The goal here is to support the process of reactivation of separation and individuation and to lay the foundation for building emotional consistency and a stable, integrated personality.

Support for families and relatives

Finally, we point out that the GET treatment also includes support for families and people who live with or are close to a person suffering from BPD — whether they are family members, partners, roommates, etc. This kind of support is crucial considering the increasingly younger age of patients and the fact that in most cases they still live in families or otherwise have close ties to them and considering the importance of the environmental factor in the evolution of the disorder.

The GET method provides support through groups and each group is made up of about 5–6 family "units", so around 10–12 people in total. It's a closed group (so no new people join once it starts) and it lasts for around one year, with one session per month. Each session lasts 90 minutes and is generally split into the following parts:

- **Sharing, discussion, support**: family members talk about how they're doing and what is happening in their relationship with their loved ones. The focus is on intra-family dynamics rather than on the patients themselves.
- **Focused analysis on specific topics, from the family experience's point of view**: another part of the session is about reviewing some "homework" or exercises that the group gets each time. These are meant to help people become more aware of what's really going on in their family relationships — the emotions, patterns, and behaviors that show up in their daily life.
- **Psychoeducation**: it's a part dedicated to educational content about psychological concepts and emotional/relationship dynamics.

Some data about method efficacy

To date, the available studies highlight that GET shows significant outcomes in the reduction of emotional dysregulation, self-harming behaviors, and suicidal behaviors (Gaj *et al.*, 2016; Visintini *et al.*, 2020). In addition, the comparison with DBT has shown a substantial equivalence in the reduction of target variables after one year of treatment (Carretta *et al.*, 2015; Roder *et al.*, 2017; Visintini *et al.*, 2020). A study conducted by Visintini and colleagues (2020), that compared GET and DBT, reached comparable outcomes on target variables. In fact, it was reported that suicidality, self-harm, emotional and behavioral dysregulation decreased in both groups after one year of treatment. Strategies to regulate intense emotions and mindfulness skills improved better in GET for the patients who completed the entire treatment, compared to drop-outs.

In a recent study, conducted by Fortaner-Uyà and colleagues (2025), it was demonstrated that DBT and GET psychotherapy programs were comparable in terms of improvement of BPD symptoms: 6 months of both treatments were associated with a significant reduction of emotional dysregulation and aggression dimensions, confirming that the two different interventions did not represent a source of heterogeneity.

The GET model is currently used in outpatient and community settings. In both, it has shown a good adaptability and flexibility to be

implemented in different health care settings. Even if more accurate research and studies are required, the available efficacy outcomes are encouraging.

Brief comparison among some aspects of the different approaches

Each of the model described has specific techniques and modes of interventions, and share many similar aspects: they all show efficacy on recovery of borderline sufferance; they are all manualized, structured, and have a theoretical coherence; they are relatively long treatments (they last more than one year), they have a clear focus, and they primarily target patients' affective experience and the therapeutic relationship.

In order to obtain a very profound and lasting modification of behavior and mental processes, we claim -based on our clinical experience- that it is essential a therapy group. Accordingly, specific psychotherapy for BPD, such as DBT and MBT, are group therapy and this kind of setting has provided great therapeutic potential (Hernandez-Bustamante *et al.*, 2024; Vogt *et al.*, 2019).

At the same time, even though many of the therapeutic approaches described in this article are based on group settings, the group in GET therapy is conceptualized in a different way as described in the comparison with DBT. In fact, in GET treatment we observe that when people are in an experiential group, they are not only attentive to comprehend and conceptualize the contents, but – at the same time – they experience and observe the processes brought by the relationships with the other members. In short, they experience what Lewin (1951) defined as a state of interdependence of fate and of task.

Our patients – during Phase 0 – learn to accept the group dimensions as safe and trustworthy. This allows the changes. It is important to highlight that the main goal of GET is not only to overcome symptomatology, but also to gain back the personal evolution of the individual (school, work, and relationships). In fact, this is linked to our vision of the borderline sufferance that we try to synthesize.

Comparing DBT and GET, other similarities are: the importance of emotional management, the main focus of the body through the development of the ability of mindfulness, the work on the reduction of at risk behaviors and the development of relational capacities.

Nevertheless, they are very different in the methodology and in the instruments used to achieve the treatment and the recovery. Hence, we can say that DBT is a "therapy in group" and GET is a "group therapy". In GET, the changes are facilitated and supported through the personal experience in the present.

Regarding the MBT treatment, as we described, the group also plays a key role in providing a context for social interaction and confrontation that facilitates growth and change. As it is conceived in GET, the MBT group offers the valuable opportunity to induce people to interact with each other and everything that happens in the group can be discussed in individual sessions, and vice versa.

Furthermore, some differences between the models explained concern the figure of the therapist: in DBT, MBT and especially in TFP, the therapist has a central role, meanwhile in GET the therapist's role is complementary to the role of the group.

DBT favors supportive interventions like giving advice and providing specific problem-solving skills. These types of interventions are only moderately recommended in MBT and it is discouraged in TFP. In GET, the main function of the facilitator or tutor is not to teach nor suggest specific tools to be applied, but to foster self-understanding through interactions with peers. In other words, the DBT therapist is steady, pragmatic and validating.

In MBT, the therapist is more participative than in GET, leading the discussion and offering constructive feedback. However, as in GET, the MBT therapist encourages everyone's participation and helps to keep the focus on their own experiences and interpersonal relationships.

Differently from GET, MBT can be applied even only in single interventions with the patient. During these sessions, the therapist is collaborative, explorative and restraining, using "non-knowledgeable" questions.

In TFP, the therapist uses confrontation, clarification and interpretation: he/she focuses on the analysis of transference, i.e., the relationship between patient and therapist. The therapist is considered as a mirror and observer of the transfer dynamics. Accordingly, the interpretation, in TFP, is fundamental, since it is a useful instrument in helping patients to connect different mental states previously dissociated, but by being still consciously aware in the therapeutic relationship.

In GET, the interpretation is not used since it is considered not acceptable for a patient with an underdeveloped Self, who could misinterpret the meaning of the interpretation. Hence, for GET, MBT, and DBT, this technique is considered as dangerous and harmful as it imposes the patient to elaborate an interpretation that might not completely correspond to his/her mental state.

Considering now the TFP and GET treatments, they both have the main goal to work on the split and the identity integration. It is essential to underline that GET treatment – unlike TFP – works first on the symptomatology with a cognitive and phenomenological approach, and then, during phase 2, on the identity with a more psychodynamic approach.

The four approaches described also differ in their philosophy of change and therapeutic goals. At the same time, there can also be parallels. The most evident benefits of the therapeutic treatments described regard behaviors of self-harming, suicidal ideations, and suicide attempts.

In order to better explain, in DBT, change is based on the dialectic between acceptance and change. Motivation is central. The patient is validated in his pain, but guided step by step to change dysfunctional behaviors through active learning of skills.

In MBT, change occurs by restoring and strengthening the ability to mentalize. The therapeutic relationship is used to reactivate interrupted mental processes. Hence, the goals are -in addition to developing and stabilizing the ability to mentalize – prevent acting-out and promote more stable and coherent relational functioning; strengthen the sense of self through interaction with the therapist and the group.

In TFP, the therapist works in the transference. The change is structural and profound and occurs through the integration of split representations of self and other, transforming a borderline structure into a more integrated one; making disturbed internal relational patterns that are activated in the transference aware; processing pathological object relations through intensive transference and countertransference analysis; promoting a more cohesive and stable sense of self.

Lastly, we want to emphasize how in GET, the integrated approach between different traditions and schools of thought allows us to consider therapeutic goals and recovery as a very complex system, involving behavior up to self-image and identity. Indeed, we use a module

that summarizes the different therapeutic goals at different stages of treatment. In Phase 0, the goals concern constancy and frequency in treatment, recognition of critical behavior, pharmacological compliance, the ability to see the other as a group, and compliance with the contract. In Phase 1, the following are added to those just described: the reduction of the use of regulatory behavior, the identification and acceptance of one's own critical areas, the tolerance of frustration, the development of an internal locus of control, the expansion of an emotional dictionary, the ability to be in the here and now and the ability to mentalize. In Phase 2, the therapeutic goals are: the absence of crises, identity stability, awareness of emotions and thoughts, persistence and constancy aimed at achieving defined goals, a substantial improvement in quality of life and the development of interpersonal skills. In summary, GET helps to support identity and the ability to reflect on oneself in relation to others, increase emotional tolerance and affect regulation, promote the expression and mentalization of interpersonal dynamics in the here and now, build a group mind, in which the individual can recognize himself as part of a relational whole.

Conclusions

The "borderline world" is very complex, and it represents a challenge on a diagnostic, therapeutic and relational level. In this article, we drew our vision of borderline functioning as the result of the virtuous interaction and integration of certain theoretical elements, presented within the paper.

According to our view, in borderline functioning, the cornerstones of the patient's suffering are: the crisis triggered by the process of emotional dysregulation, social avoidance, intolerability of contact with the emotional world and the body, the difficulties and conflict of object relations.

Throughout the article, we wanted to emphasize that behind the complexity there is a valid reason: a borderline person feels emotions as unbearable because the emotions are too intense and pervasive; so, they search for a way to survive the intolerability by different behaviors and strategies (e.g., self-harming) (Shaw, 2016).

Based on this theoretical approach and based on our clinical

experience, we have developed a new psychotherapeutic method: GET. The specificity of GET derives from integration of different theoretical and clinical influences through various group activities that constitute its uniqueness and originality. The group is the core and the heart of our treatment.

To better frame our proposal, we have briefly outlined the main treatments specific to borderline disorder: DBT, MBT and TFP. As we described, all the treatments are effective in the treatment of borderline personality disorder. Until now, research reported that the changes achieved with the treatment have demonstrated stability and duration in the long run for all of the treatments we mentioned (Carretta *et al.*, 2015; Juanmartí, & Lizeretti, 2017; Ellison *et al.*, 2020; Crotty *et al.*, 2023). This confirms the necessity of a specific psychotherapeutic treatment for BPD, if we want to achieve a recovery (Oud *et al.*, 2018).

Finally, we add that we do not believe that there is one treatment that is better than another, but that each individual patient, based on one's personality traits, resources and availability, can achieve better goals and a recovery with a specific treatment, which is why it is important to evaluate on a case-by-case, by a psychodiagnostics pathway (Kaiser *et al.*, 2023; Bucher *et al.*, 2019).

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